DOCUMENT RESUME

ED 425 233 UD 032 645

TITLE	Substance Abuse. A Resource Aid Packet.
INSTITUTION	California Univ., Los Angeles. Center for Mental Health Schools.
SPONS AGENCY	Health Resources and Services Administration (DHHS/PHS), Washington, DC. Maternal and Child Health Bureau.
PUB DATE	1998-00-00
NOTE	93p.
PUB TYPE	Reference Materials - General (130)
EDRS PRICE	MF01/PC04 Plus Postage.
DESCRIPTORS	Elementary Secondary Education; Evaluation Methods; *Health Education; *Identification; Internet; Models; Program Descriptions; Reference Materials; *Resource Materials; Screening Tests; *Substance Abuse; *Urban Schools; Urban Youth; Youth Problems

ABSTRACT

This resource provides tools that are relevant to understanding the nature and scope of substance abuse. The tools are also meant to be helpful in identifying and guiding students who need help and in preventing substance abuse. The aids are grouped into five sections. Section I provides basic fact sheets on substance abuse among youth. Section II offers guides and tools related to screening and assessment, including a guide to major assessment tools, a summary outline of indicators of abuse, and an example of a substance abuse screening checklist. Section III offers a set of information fact sheets on major substances that are abused. Information on prevention and treatment is provided in section IV, which contains descriptions of model school-based programs and guides to self-help resources and additional health education materials. Section V outlines resources for more information and support, including Internet sites, centers, agencies, advocacy groups, and relevant publications. (Author/SLD)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED 425 233

Mental Health in Schools
Center
Training and Technical Assistance

From the Center's Clearinghouse ...[*]

A resource aid packet on

Substance Abuse

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION
CENTER (ERIC)
☒ This document has been reproduced as received from the person or organization originating it
☐ Minor changes have been made to improve reproduction quality

- Points of view or opinions stated in this document do not necessarily represent official OERI position or policy

PERMISSION TO REPRODUCE AND
DISSEMINATE THIS MATERIAL HAS
BEEN GRANTED BY
Perry Nelson
UCLA - CMHS
TO THE EDUCATIONAL RESOURCES
INFORMATION CENTER (ERIC)

1

UD032645

---

[*]The Center is co-directed by Howard Adelman and Linda Taylor and operates under the auspices of the School Mental Health Project, Dept. of Psychology, UCLA, Los Angeles, CA 90095-1563 -- Phone: (310) 825-3634.

Support comes in part from the Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health.

U.S. Department of Health & Human Services
Public Health Service
HRSA
Health Resources & Services Administration
Maternal & Child Health Bureau
Office of Adolescent Health

UCLA CENTER FOR MENTAL HEALTH IN SCHOOLS*

Under the auspices of the School Mental Health Project in the Department of Psychology at UCLA, our center approaches mental health and psychosocial concerns from the broad perspective of addressing barriers to learning and promoting healthy development. Specific attention is given policies and strategies that can counter fragmentation and enhance collaboration between school and community programs.

MISSION: ***To improve outcomes for young people by enhancing policies, programs, and practices relevant to mental health in schools.***

Through collaboration, the center will

- enhance practitioner roles, functions and competence
- interface with systemic reform movements to strengthen mental health in schools
- assist localities in building and maintaining their own infrastructure for training, support, and continuing education that fosters integration of mental health in schools

Consultation Cadre ***Clearinghouse***

Newsletter ***National & Regional Meetings***

Electronic Networking

Guidebooks ***Policy Analyses***

Co-directors: Howard Adelman and Linda Taylor
Address: UCLA, Dept. of Psychology, 405 Hilgard Ave., Los Angeles, CA 90095-1563.
Phone: (310) 825-3634 FAX: (310) 206-8716 E-mail: smhp@ucla.edu
Website: http://smhp.psych.ucla.edu/

*In 1996, two national training and technical assistance centers focused on mental health in schools were established with partial support from the U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health. As indicated, one center is located at UCLA; the other is at the University of Maryland at Baltimore and can be contacted toll free at 1-(888) 706-0980.

(6/98)

Mental Health in Schools
Center
Training and Technical Assistance

What is the Center's Clearinghouse?

The scope of the Center's Clearinghouse reflects the School Mental Health Project's mission -- to enhance the ability of schools and their surrounding communities to address mental health and psychosocial barriers to student learning and promote healthy development. Those of you working so hard to address these concerns need ready access to resource materials. The Center's Clearinghouse is your link to specialized resources, materials, and information. The staff supplements, compiles, and disseminates resources on topics fundamental to our mission. As we identify what is available across the country, we are building systems to connect you with a wide variety of resources. Whether your focus is on an individual, a family, a classroom, a school, or a school system, we intend to be of service to you. Our evolving catalogue is available on request; eventually it will be accessible electronically over the Internet.

What kinds of resources, materials, and information are available?

We can provide or direct you to a variety of resources, materials, and information that we have categorized under three areas of concern:

- Specific psychosocial problems
- Programs and processes
- System and policy concerns

Among the various ways we package resources are our *Introductory Packets, Resource Aid Packets, special reports, guidebooks*, and *continuing education units.* These encompass overview discussions of major topics, descriptions of model programs, references to publications, access information to other relevant centers, organizations, advocacy groups, and Internet links, and specific tools that can guide and assist with training activity and student/family interventions (such as outlines, checklists, instruments, and other resources that can be copied and used as information handouts and aids for practice).

Accessing the Clearinghouse

- E-mail us at **smhp@ucla.edu**
- FAX us at (310) 206-8716
- Phone (310) 825-3634
- Write School Mental Health Project/Center for Mental Health in Schools,
  Dept. of Psychology, Los Angeles, CA 90095-1563

Check out recent additions to the Clearinghouse on our Web site
http://smhp.psych.ucla.edu

All materials from the Center's Clearinghouse are available for a minimal fee to cover the cost of copying, handling, and postage. Eventually, we plan to have some of this material and other Clearinghouse documents available, at no-cost, on-line for those with Internet access.

If you know of something we should have in the clearinghouse, let us know.

U.S. Department of Health & Human Services
Public Health Service
HRSA
Health Resources & Services Administration
Maternal & Child Health Bureau
Office of Adolescent Health

Preface

Those of you working so hard to address barriers to student learning and promote healthy development need ready access to resource materials. The Center's Clearinghouse supplements, compiles, and disseminates resources on topics fundamental to enabling students to learn. Among the various ways we package resources are our *Resource Aid Packets.*

Resource Aid Packets are designed to complement our series of Introductory Packets. These resource aids are a form of *tool kit* related to a fairly circumscribed area of practice. The packets contain materials to guide and assist with staff training and student/family interventions. They include overviews, outlines, checklists, instruments, and other resources that can be reproduced and used as information handouts and aids for training and practice.

This Resource Aid on *Substance Abuse* is designed to provide some tools that are relevant to (a) understanding the nature and scope of substance use/abuse, (b) appropriately identifying and guiding students who need help, (c) preventing abuse, and (d) pursuing additional resources. The aids are grouped into five sections:

> Section I provides basic facts sheets on substance abuse among youngsters.
>
> Section II offers guides and tools relevant to screening/ assessment, including a guide to major assessment tools, a summary outline of indicators of abuse, and an example of a substance abuse screening checklist.
>
> Section III offers a set of information fact sheets on major substances that are abused.
>
> Section IV provides information on prevention and treatment, including model school-based programs and self-help resources and guides to additional health education materials.
>
> Section V outlines resources for more information and support, including Internet sites, centers, agencies, advocacy groups, and relevant publications.

SUBSTANCE ABUSE

One of the nation's educational goals is to establish schools as safe and drug free zones in a community. This aid is designed to provide some tools relevant to (a) understanding the nature and scope of substance use/abuse, (b) appropriately identifying and guiding students who need help, (c) preventing abuse, and (d) pursuing additional resources.

Introduction

Keeping a Perspective on the Problem of Substance Abuse

Section I

Fact Sheets

In this section, you will find information sheets offering data on

(1) **Adolescent Substance Use and Abuse**

(2) **Teenagers and Drug Abuse**

Section II

Screening/Assessment Tools

In this section, you will find the following aids:

(1) **Information on a Sample of Substance Abuse Assessment Tools**

This document summarizes conclusions from a recent critical review of substance abuse measures, provides a brief annotated listing of available tools, and lists related references.

(2) **Summary Outline: Being Specifically Alert to Substance Abuse Indicators**

This summary focuses specifically on indicators of substance abuse. It can be used as a handout to educate others (staff, older students, parents) on what to look for related to behaviors and mood.

(3) **a Substance Abuse Checklist**

This screening tool exemplifies the types of concerns that usually are addressed.

Section III

Information About Abused Substances

In this section, you will find *fact sheets* on

(1) **Alcohol**
(2) **Marijuana**
(3) **Cocaine/Crack**
(4) **Hallucinogens**
(5) **Opiates (narcotics)**
(6) **Stimulants (amphetamines, methamphetamine)**
(7) **Barbiturates, Sedatives, Tranquilizers**
(8) **Inhalants**
(9) **Nicotine/Tobacco**
(10) **Anabolic Steroids**
(11) **Designer Drugs**

Section IV

Substance Abuse Prevention and Treatment

In this section, you will find aids on

(1) **Understanding the Nature and Scope of Model School Based Programs**
(2) **Treatment of Ethnic Minority Substance Abusers**
(3) **Treatment of Opiate Addiction**
(4) **Treatment of Smoking Cessation**
(5) **Guide to Helplines and Self-Help Resources**
(6) **Guide to Useful Brochures and Pamphlets**

Section V

Places to Go for More Information and Support

In this section you will find

(1) **Guide to Centers, Agencies, Advocacy Groups, and Internet Resources**
(2) **Some Consultation Cadre Members Who Can Help**
(3) **Guide to Additional References**

KEEPING A PERSPECTIVE ON THE PROBLEM OF SUBSTANCE ABUSE

Working with children and adolescents isn't like family practice!

That's what health and human service providers who directly work everyday with children and adolescents try to tell colleagues who only see youngsters in the context of a family situation.

What makes working directly with young populations so challenging is the need for a broad and deep psychological and socio-cultural perspective of what motivates their behavior as they develop. Just how critical this awareness is can be seen in areas such as substance abuse, pregnancy, and teen violence. Such problems often reflect the experimentation and risk taking that is so much a part of the developmental processes of moving toward individuation and independence. Characteristic behaviors include skepticism about the warnings and advice given by adults as well as reactions against rules and authority. All this has major implications for preventing and minimizing problems.

With most youngsters, developmental transitions are made without serious upheaval; good judgement and long-term goals keep high-risk behaviors to a minimum. For too many others; the lack of good alternative ways to feel competent, self-determining and connected to others leads to problems. One of these may be substance abuse. Substances do come to play a major role in some youngster's life styles. The very fact that they are illegal and forbidden often adds to the allure.

As a major social problem, substance abuse has received a spotlight in the media. Celebrities are entering treatment programs (repeatedly), failed national drug czars resign, the media reports the seizure of millions of dollars of smuggled drugs. In too many urban centers, the underground economy and life style of substance abuse is endemic to the community. Schools try to provide drug prevention programs, but statistics show a rise in adolescent drug use.

Given that substance abuse is a multi-determined major health and social problem, what is the most responsible and effective role for school staff and programs to play? Schools must approach the problem in ways that ensure staff

- have and provide accurate information
- take the problem seriously, but are careful not to undermine their credibility through use of unbelievable scare messages (remember *Reefer Madness!*)
- implement solutions that go well beyond surveillance and punishment

And, as with all interventions, the solutions must be designed to fit the various groups and individuals who populate the school and whose relationship to substance use differs markedly.

> Many students will, because of curiosity and peer inducements, try drugs, alcohol and cigarettes. Fortunately, they stop after trying the substance once

or a few times. Such students tend to respond best to *accurate* information about immediate risks (including the risk of accidents, unsafe sex, arrest).

Some students will try drugs, alcohol, and cigarettes and find immediate gratification of various needs. This gratification often outweighs their concerns about immediate risks. Whether the substance use turns into abuse depends on many factors. Efforts to prevent this from happening must include more than information and substance abuse education. Immediate opportunities and activities that can compete with the gratification a youngster finds in substance use and that are incompatible with substance abuse are needed.

It is evident that a few students make drug use a way of life and use, sell, and reshape their choices around it. They seldom are influenced by strategies to inform and educate. They rarely are influenced by concerns about losing out on long-term goals such as graduation, college, and a career. They often don't fear health or legal consequences because they have convinced themselves they are immune, or they believe the consequences will not be all that bad. The need here is for approaches that are comprehensive, multifaceted, and integrated.

Clearly, students differ in their use and abuse. Clearly, schools must design a range of approaches that fit these differences. The range must include

- providing accurate information
- facilitating discussions that are candid and supportive
- offering support systems for those who want to stop (including counseling, mutual support groups, sponsors, alternative activities such as job training/internship programs -- in settings where drug testing won't lead to a youngster's dismissal)
- evolving integrated systems of care (with schools, families, prevention and treatment programs, law enforcement, employment incentive programs all working together).

National programs such as DARE (Drug Abuse Resistance Education) show new ways of systems coming together. By itself, however, a program such as DARE can't be effective. A sophisticated range of efforts from elementary through high school with the "right" students in the "right" programs is needed. For such a comprehensive, integrated approach to evolve, school staff must enhance their efforts to mesh with the surrounding community's programs and resources, and policy makers must adopt a vision and provide the type of support that fosters such an approach.

Section I

Fact Sheets

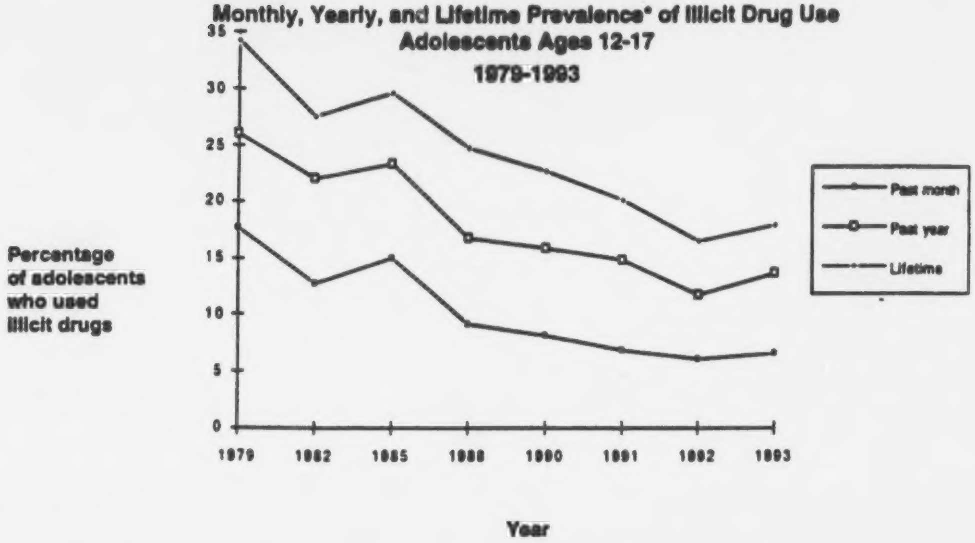
In this section, you will find information sheets offering data on

(1) **Adolescent Substance Use and Abuse**

(2) **Teenagers and Drug Abuse**

Fact Sheet on Adolescent Substance Use

Prepared by the National Adolescent Health Information Center
Division of Adolescent Medicine & Institute for Health Policy Studies
University of California, San Francisco
San Francisco, CA
November 1995

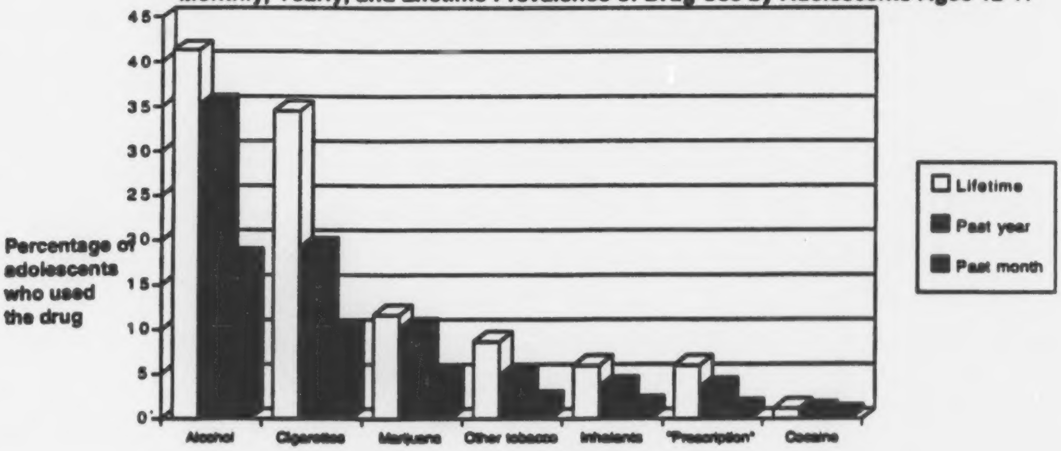

Monthly, Yearly, and Lifetime Prevalence* of Illicit Drug Use
Adolescents Ages 12-17
1979-1993

Although adolescents' use of illicit drugs had declined steadily in the past two decades, there was a .5% increase from 1992 to 1993 (from 6.1 to 6.6%).

Alcohol and cigarettes were the drugs most widely used by adolescents in 1993, followed by marijuana, smokeless tobacco, inhalants, and therapeutic drugs (used for nonmedical purposes). Over the course of their lifetimes, more than 40% of adolescents ages 12 to 17 had drunk alcohol, 35% had smoked cigarettes, and 12% had tried marijuana.

The monthly prevalence rates for alcohol, tobacco, and other drugs were substantially lower than the lifetime prevalence rates, suggesting that many adolescents who have tried substances have not continued to use them on a regular basis.

Monthly, Yearly, and Lifetime Prevalence of Drug Use by Adolescents Ages 12-17

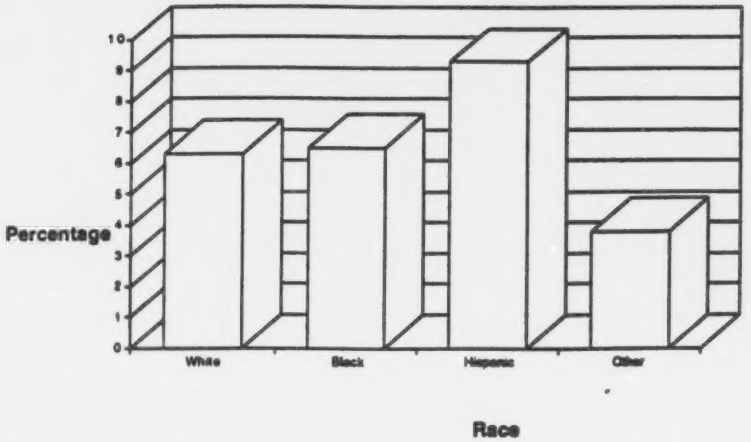


---

*Monthly prevalence = ever used in previous month; yearly prevalence = ever used in previous year; lifetime prevalence = ever used.

BEST COPY AVAILABLE

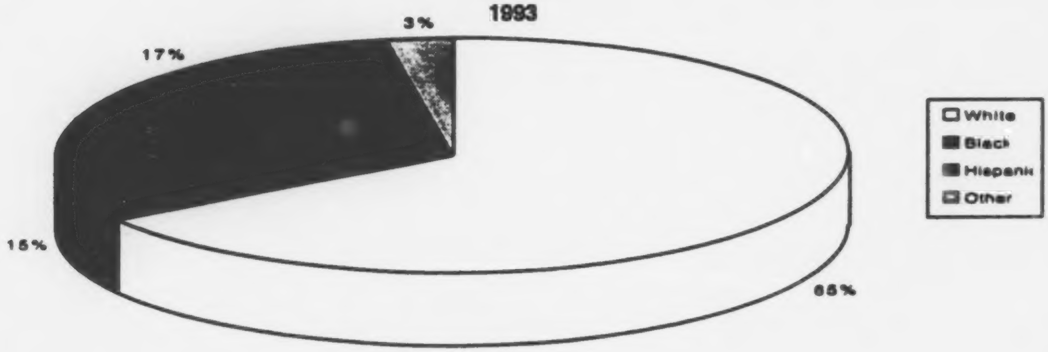
Monthly Prevalence of Illicit Drug Use by Race*
Adolescents Ages 12-17
1993



Hispanic adolescents ages 12 to 17 were more likely than non-Hispanics of other races to have used illicit drugs. More than 9% of Hispanic, 6% of Black, 6% of White, and 4% of adolescents from other races reported that they used illicit drugs in the month before they were surveyed.

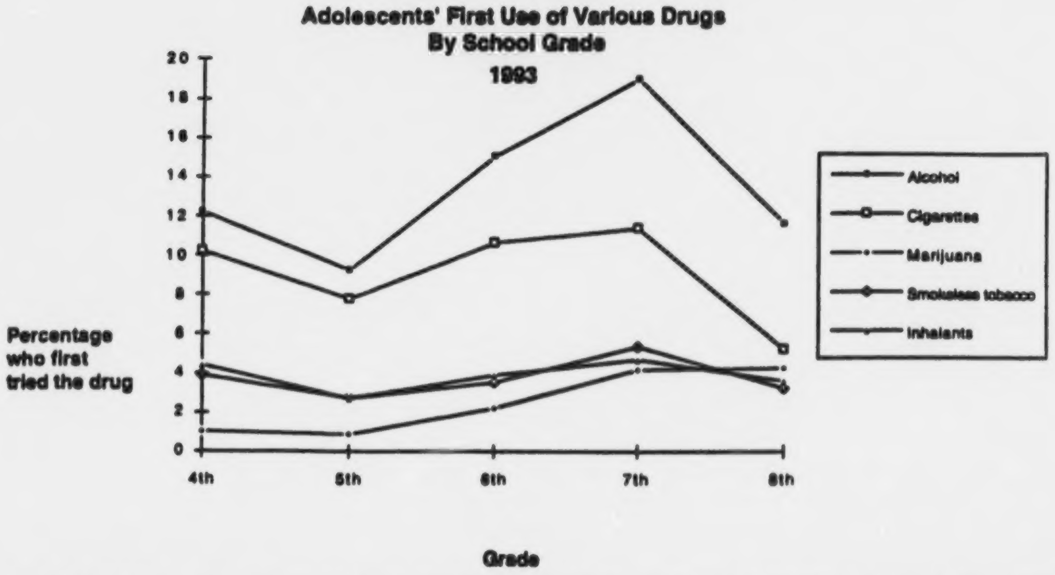
More young Hispanic adolescents ages 13-14 report annual, monthly, and daily use of alcohol and most other drugs than their Black and White peers. However, by the time adolescents are 17-18 years old, White students show the highest rates of annual, monthly, and daily use of alcohol, tobacco, and most illicit drugs, followed by Hispanics, Blacks, and Others.

Adolescents Aged 12-17 Using Illicit Drugs on a Monthly Basis
By Race
1993



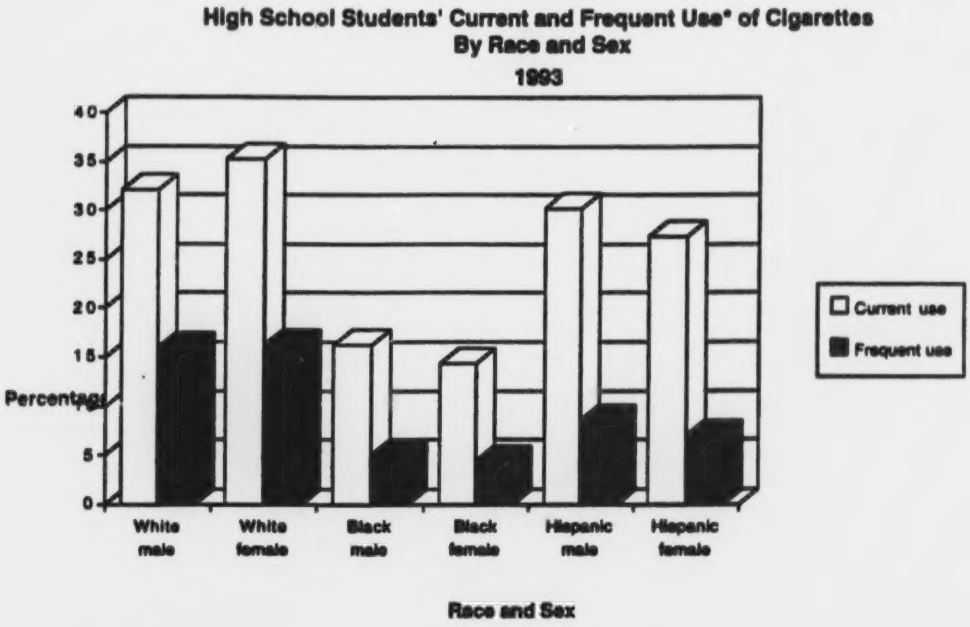
* The categories "White," "Black," and "Other" do not include members of those races of Hispanic descent.

BEST COPY AVAILABLE



Adolescents' First Use of Various Drugs
By School Grade
1993

Initiation of alcohol, cigarette, and other drug use starts early: More than 12% of adolescents reported that they first tried alcohol in 4th grade and 10% indicated that they smoked their first cigarette during the same time period. Incidence of drug use continues throughout elementary and junior high school, particularly in 6th and 7th grade (19% of adolescents reporting that they first drank alcohol and 11% reported their first cigarette in 7th grade).



High School Students' Current and Frequent Use* of Cigarettes
By Race and Sex
1993

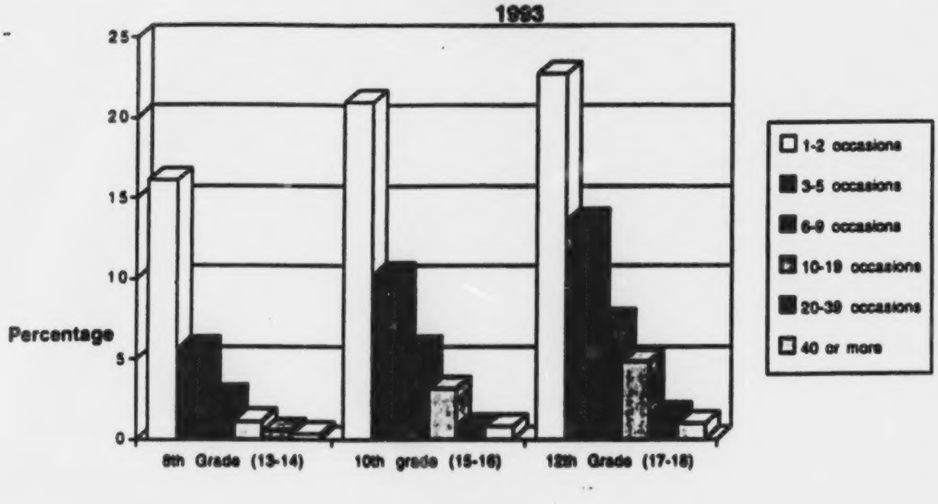
Tobacco is the drug most frequently used by high school students. White adolescents show the highest rates of cigarette use, followed by Hispanics and Blacks. Smoking is most prevalent among White females (35% are current users; 16% are frequent users) and least prevalent among Black females (14% are current users; 4% are frequent users). Smoking is almost as prevalent among Hispanic teens as among Whites.

---

* Current use = smoked cigarettes on at least one day in the previous month; frequent use = smoked cigarettes on at least 20 of the 30 days preceding the survey.

BEST COPY AVAILABLE

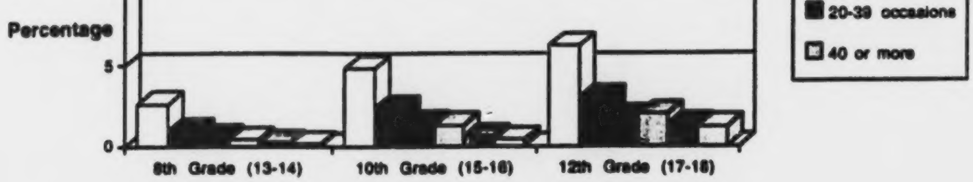
Frequency of Adolescents' Alcohol Use
Previous Month
1993



Grade (Age)

Alcohol is the second most widely-used drug by adolescents of all age groups. More than 20% of 10th and 12th graders (ages 15-18) reporting drinking alcohol on at least one occasion in the month before they were surveyed. More thån 7% indicated that they had drunk alcohol on at least 6 occasions and nearly 5% reported more than 10 occasions of alcohol use in the previous month.

Frequency of Adolescents' Marijuana Use
Previous Month
1993



Grade (Age)

Less than 5% of young people report monthly marijuana use in early and middle adolescence. Older adolescents are more likely than younger adolescents to report using marijuana on a regular basis, with 2% of 12th graders (ages 17-18) indicating that they had used marijuana at least 10 times in the previous month compared to 1.3% of 10th graders (ages 15-16) and .4% of 8th graders (ages 13-14).

BEST COPY AVAILABLE

Limited data for some ethnic minority groups:

Although national surveys regarding adolescent substance use provide information on Hispanic and Black populations, there are no specific data available regarding substance use among Native American or Asian American adolescents.

However, Indian Health Service records indicate that nearly 5 out of every 100,000 Native American young people ages 15-24 died from alcoholism in the period of 1989-91 (the U.S. all races rate was .3 per 100,000) in 1990. The alcoholism death rate for Native American males ages 15-24 was 8.6 per 100,000 compared to the U.S. all races rate of .5 per 100,000. In addition, nearly 4 out of every 100,000 Native American young people ages 15-24 died from drug-related causes in 1989-91 (compared with a rate of 2 out of every 100,000 for adolescents of other U.S. races).

Methodological information regarding the data presented here:

Data presented in this fact sheet were drawn from three surveys: the 1993 National Household Survey on Drug Abuse, the 1993 Monitoring the Future Survey, and the 1993 Youth Risk Behavior Survey. Although adolescents' substance use is investigated by all three surveys, the design and sampling of the surveys differ in some respects. Data from the National Household Survey on Drug Abuse, presented on pages 1 and 2, refer to adolescents ages 12 to 17 with no further age breakdowns. Data from the other two surveys are collected in schools and aggregated according to the school grade of the adolescents. Information presented regarding "high school students" (as in the lower half of page 3) is derived from the Youth Risk Behavior Survey while all other information on pages 3 and 4 is from the Monitoring the Future Survey. Please also note that some of the charts presented here refer to the proportion of substance use while others provide information regarding the frequency of substance use.

Data for this document:

Centers for Disease Control and Prevention (1993). Unpublished tables from the *Youth Risk Behavior Survey.*

Indian Health Service (1994). *Trends in Indian Health – 1994.* Division of Program Statistics, Office of Planning, Evaluation, and Legislation, Public Health Service, Department of Health and Human Services.

University of Michigan Institute for Social Research. Unpublished tables from the *Monitoring the Future Study, 1993.*

Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services (1994). *Preliminary Estimates from the 1993 National Household Survey on Drug Abuse.*

Sources for further information regarding adolescent substance use:

National Institute on Drug Abuse. Contact number: 301-443-6245
Substance Abuse and Mental Health Services Administration. Contact number: 301-443-7980.

The development of this fact sheet was supported in part by the Maternal & Child Health Bureau Grant # MCJ063A80, Public Health Service, Health Resources and Services Administration, Department of Health and Human Services.

BEST COPY AVAILABLE

FACTS ABOUT TEENAGERS AND DRUG ABUSE*

From the 1995 *Monitoring the Future Study*

Since 1975, the *Monitoring the Future Study* has measured the extent of drug abuse among high school seniors. Among the graduating class of 1995, 48.4 percent of students had used an illicit drug by the time they reached their senior year of high school, continuing an upward trend from 40.7 in 1992 but still far below the peak of 65.6 percent in 1981. The use of illegal drugs by adolescents increased significantly between 1992 and 1995, representing a reversal of downward trends observed for several years. Findings show that use is up for most of the drugs measured.

Use of any illicit drug in the past year (annual use) by seniors increased from 27.1percent in 1992 to 39.0 percent in 1995 after steadily declining from a peak of 54.2 percent in 1979. The percentage of seniors who had used an illicit drug within the past month (current use) increased from 14.4 percent in 1992 to 23.8 percent in 1995.

Lifetime Prevalence of Drug Abuse

	8th-graders	10th-graders	12th-graders
Marijuana	19.9%	34.1%	41.7%
Cocaine	4.2	5.0	6.0
Inhalants	21.6	19.0	17.4
LSD	4.4	8.4	11.7
Alcohol	54.5	70.5	80.7
Cigarettes	46.4	57.6	64.2

Marijuana

The lifetime and past year use of marijuana increased among 8th-, 10th-, and 12th-graders in 1995; but for 12th-graders (the only class for which long-term trends are observable), the rates are still below the high levels of the peak years of 1978 and 1979.

Among 8th-graders, increases in lifetime and annual use of marijuana first reported in 1992 continued through 1995. Between 1992 and 1995, lifetime use increased from 11.2 percent to 19.9 percent; annual use increased from 7.2 percent to 15.8 percent; and current use increased from 3.7 percent to 9.1 percent. Among 10th-graders, lifetime use of marijuana increased from 21.4 percent in 1992 to 34.1 percent in 1995. Annual use increased from 15.2 percent in 1992 to 28.7 percent in 1995, and current use increased from 8.1 percent in 1992 to 17.2 percent in 1995.

In 1995, 41.7 percent of seniors had used marijuana at least once (lifetime use), up from 32.6 percent in 1992. Annual use of marijuana among seniors peaked at 50.8 percent in 1979, decreased steadily to 21.9 percent in 1992, and increased to 34.7 in 1995. Current use increased from 11.9 percent in 1992 to 21.2 percent in 1995.

Prevalence of Marijuana Use in Past Year

	1991	1992	1993	1994	1995
8th-graders	6.2%	7.2%	9.2%	13.0%	15.8%
10th-grader s	16.5	15.2	19.2	25.2	28.7
12th-grader s	23.9	21.9	26.0	30.7	34.7

Cocaine

The use of cocaine among 8th- and 10th- graders increased between 1994 and 1995, with 4.2 percent of 8th-graders and 5.0 percent of 10th-graders having used cocaine at least once in their lives. Among 12th-graders, lifetime use remained about 6 percent from 1992 through 1995. In addition, in 1995, 1.2 percent of 8th-graders, 1.7 percent of 10th-graders, and 1.8 percent of 12th-graders had used cocainewithin the 30 days preceding the survey.

Crack cocaine use increased among 8th- and 10th-graders between 1992 and 1995; a statistically significant increase was seen from 1994 to 1995 for 10th-graders for all three prevalence measures. Survey results showed that 2.7 percent of 8th-graders, 2.8 percent of 10th-graders, and 3.0 percent of 12th-graders used crack at least once; 1.6 percent of 8th-graders, 1.8 percent of 10th-graders, and 2.1 percent of 12th-graders used crack within the preceding year; and 0.7 percent of 8th-graders, 0.9 percent of 10th-graders, and 1.0 percent of 12th-graders had used crack within the preceding month.

LSD

Lifetime use of LSD among seniors was 11.7 percent in 1995, and their annual use of LSD was 8.4 percent in 1995, surpassing the corresponding levels of use during the peak years of the mid-1970s. Annual use of LSD by 8th-graders was 3.2 percent in 1995 (up from 2.4 percent in 1994). Annual use for 10th-graders increased from 5.2 percent in 1994 to 6.5 percent in 1995.

Inhalants

Lifetime and annual use of inhalants among 8th-graders increased significantly between 1992 and 1995, making inhalants the most widely abused substances after alcohol and tobacco among this group. In 1995, more than one in five 8th-graders (21.6 percent) used inhalants, which include glues, aerosols, and solvents, at least once in their lives, the third increase since 1992 (17.4 percent). The percentage of 8th-graders using inhalants within the preceding year increased from 9.5 percent in 1992 to 12.8 percent in 1995. Lifetime rates of inhalant use among 10th-graders increased from 16.6 percent in 1992 to 19.0 percent in 1995.

Alcohol

Daily use of alcohol by high school seniors in 1995 was 3.5 percent. Among 10th-graders, daily use of alcohol was 1.7 percent in 1995, and daily use of alcohol among 8th-graders was 0.7 percent. Binge drinking (having five or more drinks in a row in the preceding 2 weeks) was reported by almost 30 percent of high school seniors, and the rate of binge drinking among 10th-graders was 24.0 percent in 1995. Among 8th-graders, the rate of binge drinking in 1994 and 1995 was 14.5 percent.

Cigarettes

The percentage of 8th-, 10th-, and 12th-graders who smoke cigarettes daily increased from 1991 to 1995. In 1995, daily smoking was reported by 21.6 percent of seniors, 16.3 percent of 10th-graders, and 9.3 percent of 8th-graders.

Students' Attitudes and Perceptions

In 1995, continuing a downward trend, significantly fewer students felt that there is great risk of people harming themselves when they use marijuana, crack, or powdered cocaine. Compared with 1994, fewer 8th-, 10th-, and 12th-graders think that people are at great risk of harming themselves by trying marijuana once or twice; fewer 8th-, 10th-, and 12th-graders think that people are at great risk of harming themselves by smoking marijuana occasionally; and fewer 10th- and 12th-graders think that people are at great risk of harming themselves by smoking marijuana regularly. Among seniors, the perceived risk of marijuana use has decreased each year since 1991; in 1995, only 60.8 percent of seniors saw great risk in regular marijuana use.

In 1995, the percentage of students in each grade who felt that people are at great risk of harming themselves by trying crack cocaine continued to decrease from1991.

From 1994 through 1995, there was an increase in the percentage of 8th-10th-, and 12th- graders who said it would be "very easy" or "fairly easy" for them to get marijuana.

The perceived availability of LSD increased among 8th- and 10th-graders from1994 to 1995.

The proportion who perceived crystal-methamphetamine (ice) as easy to get increased among 10th-graders.

For More Information

Additional information on this and related topics is available from the
National Drug Information Treatment and Referral Hotline
(800) 662-HELP(4357)

This agency supplies printed materials, information on treatment services in specific states, referrals for treatment, and other resources.

*Adapted from material provided by the National Institute on Drug Abuse, U.S. Department of Health and Human Services.

Section II

Screening/Assessment Tools

In this section, you will find the following aids:

(1) **Information on a Sample of Substance Abuse Assessment Tools**

This document summarizes conclusions from a recent critical review of substance abuse measures, provides a brief annotated listing of available tools, and lists related references.

(2) **Summary Outline: Being Specifically Alert to Substance Abuse Indicators**

This summary focuses specifically on indicators of substance abuse. It can be used as a handout to educate others (staff, older students, parents) on what to look for related to behaviors and mood.

(3) a **Substance Abuse Checklist**

This screening tool exemplifies the types of concerns that usually are addressed.

INFORMATION ON A SAMPLE OF SUBSTANCE ABUSE ASSESSMENT TOOLS

Substance abuse usually is defined with respect to an individual's inability to control use and continued use despite adverse consequences. Assessment tools in this area are meant to help identify these concerns.

In their 1994 measurement review article entitled "Assessing adolescent substance use: A critique of current measurement instruments,"* Leccesse and Waldron conclude that clinicians approaching the task of assessing adolescents are confronted with a dilemma.

> Despite the intensity of investigative efforts, . . . the field of adolescent substance abuse has been characterized as more remarkable for what we do not know than what we do know. This is especially true in the area of assessment. Most instruments are still in the developmental stages and their effectiveness for problem identification, diagnosis, and treatment planning is largely unknown. Moreover, assessment practices in many adolescent treatment facilities seem to involve either unstandardized, locally developed measures or instruments developed and normed for adults. Both of these practices are potentially problematic. . . .

These authors also caution that

> Some ambiguity exists regarding what constitutes problem substance use in adolescents. National survey data show that experimentation with some drugs (e.g., alcohol, Tobacco) is statistically normal. That is, by late adolescence, more youth have tried these substances than have not. In the case of alcohol, 90% of all high school seniors have had some drinking experience. The majority of adolescents who experiment with drugs do not become addicted. Moreover, most adolescents appear to "mature out" of problem use with a sharp drop in drug use after age 21. Alternatively, some researchers have argued that, to a degree, drug use has developmental, adaptational utility for adolescents. For example, substance use could serve to signal independence from parents and identification with peers, or opposition to or deviation from societal norms and values, both of which could be viewed as normal exploration of identity issues.
>
> However, substance use could also serve as an attempt to cope with stress associated with adolescence, or could signal a lack of regulation, reflecting less psychological health. Similarly, used as a method of gaining autonomy, as a method of negative attention seeking or gaining contact with parents, or as a way of influencing family structure, adolescent substance use could be a concomitant of family pathology. . . .
>
> Research findings do suggest that use of substances during the teen years can interfere with crucial developmental tasks . . . (and can) precipitate problems by increasing the likelihood of arrest for substance-related offenses and increasing adolescents' exposure to risky situations such as driving while intoxicated, engaging in unprotected sex, and confronting violent exchanges.

---

*Source: *Journal of Substance Abuse Treatment, 11,* 553-563. References cited by these authors related to the above points are included at the end of this section.

BEST COPY AVAILABLE

A Brief, Annotated Listing of Substance Abuse Assessment Tools

Some of the following are designed as quick screening instruments; others are used either after a youngster is identified by a screening device or in place of screening when feasible. Screening tools are relatively inexpensive and quick to administer, but they also are quite limited in their validity. Moreover, if cut-off scores are set too low, screens detect many youngsters who should not be identified (false positives).

More comprehensive instruments are designed for use in making diagnoses and planning specific interventions. All instruments in this area have limited psychometric validation; a few have generated better data than the rest. Special note is made of those rated in a fairly recent review as being better than the rest in terms of available reliability and validity findings.

Screening Tools

Unless otherwise indicated, the following are relatively brief, paper and pencil, self-report questionnaires.

Adolescent Drinking Index (Psychological Assessment Resources; Harrell & Wirtz, 1989)

Consists of 24 items focusing on loss of control and psychosocial and physical symptoms.

Adolescent Drug Involvement Scale (Moberg, 1983)

Adaptation of the Adolescent Involvement Scale (Mayer & Filstead, 1979) to focus more broadly on general substance abuse; includes a frequency of use checklist.

Client Substance Index (Olympic Counseling Services; Moore, 1983)

Consists of 113 items designed to measure 28 chemical dependency symptoms outlined by Jellinek. Scores are converted into 4 categories -- no problem, misuse, abuse, and chemically dependent.

Drug Abuse Screening Test -- Adolescent version (Skinner, unpublished)

Adaptation of an adult version (Skinner, 1982); consists of ten yes/no questions related to hard drug use.

Drug and Alcohol Problem Quick Screen (Schwartz & Wirtz, 1990)

Respondent answers "yes," no," or "uncertain" to 30 brief items asking about (a) her/his own substance use, (b) parents' and friends' substance use, (c) participation in risky behavior, (d) conflict with parents, (e) misbehavior at school, (f) beliefs about alcohol and drug use, and (g) symptoms of depression. Individuals scoring six or more are seen as "high-risks." The items are listed in an article by the instruments developers (see Schwartz & Wirtz, 1990).

Drug Use Screening Inventory (Tarter, 1990; Tarter & Hegedus, 1991)

Focuses on problems with substance use, physical and mental health, and psychosocial adjustment using 149 yes/no items written at a fifth grade reading level; takes approximately 20 minutes. No cut-off scores have been established. The items are listed in an article by Tarter (1990). This is one of two screening instruments judged by Leccese and Waldron (1994) as having the *best reliability and validity findings* as of their review.

Perceived Benefit of Drinking & Drug Use Scales (Petchers & Singer, 1987; Petchers, Singer, Angelotta, & Chow, 1988)

Consists of 10 items -- 5 parallel alcohol and drug statements about reasons people might use substances. Respondent chooses whether or not s/he agrees with each of five stated reasons. Those who agree with many of the "positive" stated reasons are seen as likely to be problem users, but no cut-off score is established. Items are available in Petchers et al. (1988).

Personal Experience Screen Questionnaire (Western Psychological Services; Winters, 1992)

This is part of a consortium developed assessment package called the *Minnesota Chemical Dependency Adolescent Assessment Profile*. This measure consists of 40 items focusing on psychosocial functioning, substance problem severity, and frequency and onset of use; includes items to detect social desirable responding. Takes about 10 minutes. No cut-off score established. This is one of two screening instruments judged by Leccese and Waldron (1994) as having the *best reliability and validity findings* as of their review.

Substance Abuse Screening Test (Slosson)

Designed to screen out students, ages 13-18 years and older, who are **unlikely** to have a substance abuse problem. Those not screened out are seen as appropriate "at risk" referrals. Consists of 30 self-report yes/no items; also includes an Observation Report to be filled out by an adult who is familiar with the student. Can be administered by any appropriately sanctioned and supervised adult; takes about 10 minutes. Available from Slosson Educational Publications, Inc., P.O. Box 280, East Aurora, NY 14052.

Substance Abuse Subtle Screening Inventory Adolescent (Miller, 1990)

Consists of 81 items and takes about 20 minutes. 55 true/false items are used as indirect measures (designed to appear unrelated to substance use); the rest ask about the frequency of occurrence of specific situations involving substance use. Available from the SASSI Institute, 4403 Trailridge Road, Bloomington, IN 47408.

Tools for Diagnosis and Treatment Planning

Adolescent Assessment and Referral System (National Institute on Drug Abuse; Rahdert, 1991)

A battery of screening measures and clinical guides for diagnosis and treatment referral. The screening battery, called the *Problem Oriented Screening Instrument for Teenagers,* consists of 139 yes/no items designed to measure functioning related to substance use (and nine other areas -- physical health, mental health, family relationships, peer relationships, educational status, vocational status, social skills, leisure and recreation, aggressive behavior/delinquency). A set of items designated as "red flags," including all substance use items, are seen as indicating the need for further assessment. That is, a yes response on any of these items designates the youngster at risk. Instrument and guides are available with a manual at no charge through the National Clearinghouse for Alcohol and Drug Information.

Adolescent Chemical Health Inventory (Renovex)

Consists of 122 items focusing on severity of direct and indirect substance use problems. Includes items to check on the degree that responses are influenced by a desire to be socially appropriate.

Adolescent Diagnostic Interview (Western Psychological Services; Winters & Henly, 1993)

This is part of a consortium developed assessment package called the *Minnesota Chemical Dependency Adolescent Assessment Profile*. It is a structured diagnostic interview covering symptoms indicating abuse or dependence as specified in the Diagnostic Statistical Manual of the American Psychiatric Association related to diagnosis of psychoactive substance use disorders. Explores use history for several drug categories and covers level of functioning and psychosocial stressors. Takes about 45-60 minutes. This is one of three instruments used for diagnosis and treatment planning judged by Leccese and Waldron (1994) as having the *best reliability and validity findings* as of their review.

Adolescent Drug Diagnosis (Friedman & Utada, 1989)

A 150-item structured interview -- modeled after an adult measure called the Addiction Severity Index (McLellan, Luborsky, Woody, & O'Brien, 1980). Besides substance use, the measure focuses on severity of problem and "need for treatment" related to medical, school, employment, social, family, psychological, and legal matters. Used in diagnosis and treatment planning (and for research). Takes about 45-60 minutes. Contact Belmont Research Center, 4081 Ford Road, Philadelphia, PA 19131. This is one of three instruments used for diagnosis and treatment planning judged by Leccese and Waldron (1994) as having the *best reliability and validity findings* as of their review.

Adolescent Problem Severity Index **(Metzger, Kushner, & McLellan, 1991)**

A semistructured interview also modeled after the Addiction Severity Index (McLellan, Luborsky, Woody, & O'Brien, 1980); can be administered by an interviewer or a computer. (Special training -- about six hours -- is recommended.) Besides substance use, treatment needs are assessed related to legal, family relationships, school and work, medical, psychosocial adjustment, and personal relationships. Both total number of risk factors in each area and severity are scored and combined into a composite indicating need for treatment. Takes approximately 45-60 min to complete. Contact David Metzger, Ph.D., Addiction Research Center, University of Pennsylvania, 3900 Chestnut Street, Philadelphia, PA 19115.

Adolescent Self-Assessment Profile (Wanberg, 1991)

Consists of 203-item multiple choice questions focusing on substance use and 5 other general areas of concern (family, mental health, peer influence, school problems, deviant behavior). These yield raw scores for 20 scales scores which can be converted to decile ranks defining degree of problem severity. Contact Kenneth W. Wanberg, Ph.D., Center for Alcohol/Drug Abuse Research and Evaluation, 5460 Ward Road, Suite 140, Arvada, CO 80002.

Personal Experience Inventory (Western Psychological Services; Winters & Henly, 1989)

This is part of a consortium developed assessment package called the *Minnesota Chemical Dependency Adolescent Assessment Profile*. Designed for treatment planning, this instrument consists of 276 items written at a fifth-grade reading level and focused on onset and frequency of drug use, severity of drug problem, personal risk factors, environmental risk factors, several other problem areas (e.g., physical and sexual abuse). Includes items to detect social desirable responding. Yields scores for five problem-severity scales: personal involvement, effects from drug use, social benefits of drug use, personal consequences of drug use, and polydrug use. Takes about 45-60 minutes. Can be administered by computer. This is one of three instruments used for diagnosis and treatment planning judged by Leccese and Waldron (1994) as having the *best reliability and validity findings* as of their review.

Substance Involvement Instrument (Aladar)

Part of an assessment package that includes sociodemographics and drug use history, this 60 item measure focuses on the extent of substance use involvement, with 20 items that are "behavioral indicators" designed to reflect the progressive nature of dependency. Contact Aladar in Lacy, WA.

Teen-Addiction Severity Index (Kaminer, Bukstein, & Tarter, 1991)

Adapted from the *Addiction Severity Index*, this measure yields seven subscales: chemical use, school status, employment-support status, family relationships, legal status, peer-social relationships, and psychiatric status. In each area, both the respondent and interviewer use a 5 point scale to indicate problem severity and need for treatment. Takes about 30-45 minutes and is to be administered only by trained personnel. Contact Y. Kaminer for more information.

BEST COPY AVAILABLE

Something a Little Different

Teen Health Advisor (Paperny, Aono, Lehman, Hammar, & Risser, 1990)

This is a computer program designed to be a relatively nonthreatening way of eliciting information on high-risk behaviors and provide feedback in the form of advice or referral sources. It covers such areas as general health, communication skills, emotional issues, substance use, teen pregnancy, contraception, and sexually transmitted diseases. Paperny et al. (1990) suggest the approach is more effective in gathering sensitive information than a clinical questionnaire. Data from studies conducted in Hawaiian public schools are available from the first author. The computer program can be ordered from: Teen Health Computer, 2516 Pacific Heights Road, Honolulu, HI 96813.

References

Aladar (1987). *Substance Involvement Instrument.* Lacy. WA: Cascade Oaks.

Bailey, G.W. (1989). Current perspectives on subtance use in youth. *Journal of the American Acadmy of Child and Adolescent Psychiatry, 28*, 151-162.

Bentler, P.M. (1992). Etiologies and consequences of adolescent drug use: Implications for prevention. *Journal of Addictive Diseases, 11*, 47-61.

Donovan, J.E. (1993, June). *Knowledge gaps in current understanding of adolescent alcohol abuse.* Paper presented at the annual meeting of the Research Society on Alcoholism. San Antonio, Texas.

Farrell, A.D., Danish, S.J., & Howard, C.W. (1992). Relationship between drug use and other problem behaviors in urban adolescents. *Journal of Consulting and Clinical Psychology, 60*, 705-712.

FeCaces, M., Stinson, F.S., & Hartford, T.C. (1991). Alcohol use and physically risky behavior among adolescents. *Alcohol Health and Research World, 15*, 228-233.

Friedman, A.S., & Utada, A. (1989). A method for diagnosing and planning the treatment of adolescent drug abusers: The Adolescent Drug Abuse Diagnosis (ADAD) instrument. *Journal of Drug Education, 19*, 285-312.

Harrell, A.V., & Wirtz, P.W. (1989). *Adolescent Drinking Index Test and Manual.* Odessa, FL: Psychological Assessment Resources.

Hawkins, J.D., Catalano, R.F., & Miller, J.Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin, 112*, 64-105.

Johnston, L.D., Bachman, J.G., & O'Malley, P.M. (1991). *Monitoring the future: Questionnaire responses from the nation's high school seniors 1990.* Ann Arbor, MI: University of Michigan, Institute for Social Research.

Kaminer, Y., Bukstein, O., & Tarter, R.E. (1991). The Teen Addiction Severity Index: Rationale and reliability. *International Journal of the Addictions, 26*, 219-226.

Kouzis, A.C., & Labouvie, E.W. (1992). Use intensity, functional elaboration, and contextual constraint as facets of adolescent alcohol and marijuana use. *Psychology of Addictive Behaviors, 6*, 188-195.

Labouvie, E.W. (1986). The coping function of adolescent alcohol and drug use. In R.K. Silbereisen, K. Eyferth, & G. Rudinger (Eds.), *Development as action in context: Problem behavior and normal youth development*. New York: Springer-Verlag.

Leccese, M. & Waldron, H.B. (1994). Assessing adolescent substance use: A critique of currentmeasurement instruments. *Journal of Substance Abuse Treatment, 11*, 553-563.

Mayer, J., & Filstead, W.J. (1979). The Adolescent Alcohol Involvement Scale: An instrument for measuring adolescents' use and misuse of alcohol. *Journal of Studies on Alcohol, 40*, 291-300.

McLellan, A.T., Luborsky, L., Woody, G.E., & O'Brien, C.P. (1980). An improved diagnostic evaluation instrument for substance abuse patients: The Addiction Severity Index. *Journal of Nervous and Mental Disease, 168*, 26-33.

Metzger, D.S., Kushner, H., & McLellan, A.T. (1991). *Adolescent Problem Severity Index Administation Manual.* Philadelphia: Biomedical Computer Research Institute.

Miller, G. (1990). *Substance Abuse Subtle Sceening Inventory-Adolescent (SASSI-A).* Bloomington, IN: SASSI Institute.

Miller, W.R., & Brown, J.M. (1991). Self-regulation as a conceptual basis for the prevention and treatment of addictive behaviours. In N. Heather, W.R. Miller, & J. Greeley (Eds.), *Self-control and the addictive behaviours* (pp. 3-79). Sydney: Maxwell MacMillan Publishing, Australia.

Moberg, D.P. (1983). Identifying adolescents with alcohol problems: A field test of the Adolescent Alcohol Involvement Scale. *Journal of Studies on Alcohol, 44*, 701-721.

Moore, D. (1983). *Client Substance Index.* Olympia, WA: Olympic Counseling Services.

Owen, P.L., & Nyberg, L.R. (1983). Assessing alcohol and drug problems among adolescents: Current practices. *Journal of Drug Education, 13,* 249-254.

Paperny, D.M., Aono, J.Y., Lehman, R.M., Hammar, S.L., & Risser, J. (1990). Computer-assisted detection and intervention in adolescent high-risk health behaviors. *Journal of Pediatrics, 116*, 456-462.

Petchers, M.K., & Singer, M.I. (1987). Perceived Benefit of Drinking Scale: Approach to screening for adolescent alcohol abuse. *Journal of Pediatrics, 110,* 977-981.

Petchers, M.K., Singer, M.I., Angelotta, J.W., & Chow, J. (1988). Revalidation and expansion of an adolescent substance abuse screening measure. *Developmental and Behavioral Pediatrics, 9*, 25-29.

Rahdert, E.R. (Ed.) (1991). *The Adolescent Assessment/Referral System Manual.* Rockville, MD: U.S. Department of Health and Human Services.

Raveis, V.H., & Kandel, D.B. (1987). Changes in drug behavior from middle to late twenties: Initiation, persistence, and cessation of use. *American Journal of Public Health, 77,* 607-611.

Schwartz, R.H., & Wirtz, P.W. (1990). Potential substance abuse detection among adolescent patients using the drug and alcohol (DAP) quick screen, a 30-item questionnaire. *Clinical Pediatr,ics, 29,* 38-43.

Shedler, J., & Block, J. (1990). Adolescent drug use and psychological health: A longitudinal inquiry. *American Psychologist, 45,* 612-630.

Skinner, H.A. (1982). The Drug Abuse Screening Test, *Addictive Behaviors, 7*, 363-371. (The Adolescent Version is unpublished.

Stanton, M.D., & Todd, T.C. (1982). *The family therapy of drug abuse and addiction.* New York: Guilford Press.

Szapocznik, J., Kurtines, W.M., Foote, F.H., Perez-Vidal, A., & Hervis, 0. (1983). Conjoint versus one-person family therapy: Some evidence for the effectiveness of conducting family therapy through one person with drug-abusing adolescents. *Journal of Consulting and Clinical Psychology, 51*, 889-899.

Tarter, R.E. (1990). Evaluation and treatment of adolescent substance abuse: A decision tree method. *American Journal of Drug and Alcohol Abuse, 16*, 1-46.

Tarter, R.E., & Hegedus, A.M. (1991). The Drug Use Screening Inventory: Its application in the evaluation and treatment of alcohol and other drug abuse. *Alcohol Health and Research World, 15*, 65-75.

Wanberg, K.W. (1991). *Adolescent Self-Assessment Pofile.* Arvada, CO: Center for Alcohol/Drug Abuse Research and Evaluation.

Winters, K.C. (1990). The need for improved assessment of adolescent substance involvement. *Journal of Drug Issues, 20*, 487-502.

Winters, K.C. (1992). Development of an adolescent alcohol and other drug abuse screening scale: Personal Experience Screening Questionnaire. *Addictive Behaviors, 17*, 479-490.

Winters, K.C., & Henly, G.A. (1989). Personal Experience Inventory Test and Manual.. Los Angeles: Wetern Psychological Services.

Winters, K.C., & Henly, G.A. (1993). *Adolescent Diagnostic Interview Schedule and Manual.* Los Angeles: Western Psychological Services.

Summary Outline:

Being Specifically Alert to Substance Abuse Indicators

It is essential to remember that many of the symptoms of substance abuse are common characteristics of young people, especially in adolescence. This means *extreme caution* must be exercised to avoid misidentifying and inappropriately stigmatizing a youngster. *Never* overestimate the significance of a few indicators.

The type of indicators usually identified are

- a *prevailing pattern* of unusual and excessive behaviors and moods
- recent *dramatic* changes in behavior and mood.

School staff and those in the home should be concerned if they note

- poor school performance; skipping or ditching school
- inability to cope well with daily events
- lack of attention to hygiene, grooming, and dress
- long periods alone in bedroom/bathroom apparently doing nothing
- extreme defensiveness; negative attitudes; dissatisfied about most things; argumentative
- frequent conflicts with others; verbally/physically abusive
- withdrawal from long-time friends/family/activities
- disregard for others; extreme egocentricity
- taking up with new friends who may be drug users
- unusual tension or depressed states
- seems frequently confused and "spacey"
- often drowsy
- general unresponsiveness to what's going on (seems "turned off")
- increasing need for money; disappearance of possessions (e.g., perhaps sold to buy drugs); stealing/shoplifting
- excessive efforts to mislead (lying, conning, untrustworthy, insincere)
- stooped appearance and posture
- dull or watery eyes; dilated or pinpoint pupils
- sniffles; runny nose
- overt indicators of substance abuse (e.g., drug equipment, needle marks)

In the period just after an individual has used drugs, one might notice mood and behavioral swings -- first euphoria, perhaps some unusual activity and/or excessive talking, sometimes a tendency to appear serene, after a while there may be a swing toward a depressed state and withdrawal. Sometimes the individual will stare, glassy-eyed at one thing for a long time.

To be more specific about a few indicators of abuse categorized by some common substances that are abused:

Amphetamines (stimulants)

- excessive activity
- rapid speech
- irritability
- appetite loss
- anxiety
- extreme moods and shifts
- erratic eating and sleeping patterns
- fatigue
- disorientation and confusion
- increased blood pressure and body temp.
- increased respiration
- increased and irregular pulse
- tremors

Cocaine (stimulant, anesthetic)

- short-lived euphoria followed by depression
- nervousness and anxiety
- irritability
- shallow breathing
- fever
- tremors
- tightening muscles

Inhalants

- euphoria
- intoxicated look
- odors
- nausea
- drowsiness
- stupor
- headaches
- fainting
- poor muscle control
- rapid heartbeat
- anemia
- choking

Cannabinoids (e.g., marijuana, hash, THC)

- increased appetite initially
- decreased appetite with chronic use
- euphoria
- decreased motivation for many activities
- apathy, passivity
- decreased concentration
- altered sense of time and space
- inappropriate laughter
- rapid flow of ideas
- anxiety; panic
- irritability, restlessness
- decreased motor skill coordination
- characteristic odor on breath and clothes
- increased pulse rate
- droopy, bloodshot eyes
- irregular menses

Narcotics (e.g., opium, heroin, morphine, codeine, methadone, and other pain killers)

- extreme mood swings
- poor concentration
- confusion
- insensitivity to pain
- drowsiness/decreased respiration
- slow, sallow breathing
- decreased motor coordination
- itchiness
- watery eyes/pinpoint pupils
- lethargy
- weight loss
- decreased blood pressure
- possible needle marks
- as drug wears off nausea & runny nose

Barbiturates, sedatives, tranquilizers (CNS depressants)

- decreased alertness
- intoxicated look
- drowsy
- decreased motor coordination
- slurred speech
- confused
- extreme mood swings
- erratic eating and sleeping patterns
- dizzy
- cold, clammy skin
- decreased respiration and pulse
- dilated pupils
- depressed mood state
- disinhibition

Hallucinogens (effecting perceptions; e.g., PCP, LSD, mescaline)

- extreme mood alteration and intensification
- altered perceptions of time, space, sights, sounds, colors
- loss of sense of time, place, person
- decreased communication
- panic and anxiety
- paranoia
- extreme, unstable behaviors
- restlessness
- tremors
- nausea
- flashbacks
- increased blood pressure
- impaired speech
- impaired motor coordination
- motor agitation
- decreased response to pain
- watery eyes

BEST COPY AVAILABLE

SUBSTANCE ABUSE CHECKLIST*

It is essential to remember that many of the symptoms of substance abuse are common characteristics of young people, especially in adolescence. This means *extreme caution* must be exercised to avoid misidentifying and inappropriately stigmatizing a youngster. *Never* overestimate the significance of a few indicators.

Student's Name ____________________________ Age _____ Birthdate ____________

Date: ________ Interviewer ________________________

(Suggested points to cover with student, parent, other informed sources)

(1) Substance Use

Has the individual used substances in the past? Y N

In the last year or so? Y N

Does the individual currently use substances? Y N

Does the individual feel s/he has a substance abuse problem? Y N

If so, does s/he want help in dealing with the problem? Y N

How often does the individual	Never	Once in a while,	About Once a Week	Several Times a Week	Every Day
drink beer, wine or hard liquor?	1	2	3	4	5
smoke cigarettes?	1	2	3	4	5
smoke marijuana (pot)?	1	2	3	4	5
use a drug by needle?	1	2	3	4	5
use cocaine or crack?	1	2	3	4	5
use heroine?	1	2	3	4	5
take LSD (acid)?.	1	2	3	4	5
use PCP (angel dust)?	1	2	3	4	5
sniff glue (huff)?	1	2	3	4	5
use speed?	1	2	3	4	5
other? (specify)_______________	1	2	3	4	5

Has the individual ever had treatment for a substance problem? Y N

Has anyone observed the individual with drug equipment, needle marks, etc.? Y N

---

*Use this checklist as an exploratory guide with students about whom you are concerned. Because of the informal nature of this type of assessment, it should not be filed as part of a student's regular school records.

(2) Recent Dramatic Changes in Behavior and Mood

Have there been major changes recently with respect to the individual's

relationship with family members?	Y	N
relationship with friends?	Y	N
performance at school?	Y	N
attendance at school?	Y	N
participation in favorite activities?	Y	N
attitudes about things in general?	Y	N

(3) Prevailing Behavior and Mood Problems

Have any of the following been noted:

poor school performance	Y	N
skipping or ditching school	Y	N
inability to cope well with daily events	Y	N
lack of attention to hygiene, grooming, and dress	Y	N
long periods alone in bedroom/bathroom apparently doing nothing	Y	N
extreme defensiveness; argumentative	Y	N
negative attitudes	Y	N
dissatisfied about most things	Y	N
frequent conflicts with others	Y	N
verbally/physically abusive	Y	N
withdrawal from long-time friends	Y	N
withdrawal from family	Y	N
withdrawal from favorite activities	Y	N
disregard for others; extreme egocentricity	Y	N
taking up with new friends who may be drug users	Y	N
unusual tension or depressed states	Y	N
seems frequently confused and "spacey"	Y	N
often drowsy	Y	N
general unresponsiveness to what's going on (seems "turned off")	Y	N
increasing need for money	Y	N
disappearance of possessions (e.g., perhaps sold to buy drugs)	Y	N
stealing/shoplifting	Y	N
excessive efforts to mislead (lying, conning, untrustworthy, insincere)	Y	N
stooped appearance and posture	Y	N
dull or watery eyes; dilated or pinpoint pupils	Y	N
sniffles; runny nose	Y	N

Section III

Information About Abused Substances

In this section, you will find *fact sheets* on

1. **Alcohol**
2. **Marijuana**
3. **Cocaine/Crack**
4. **Hallucinogens**
5. **Opiates (narcotics)**
6. **Stimulants (amphetamines, methamphetamine)**
7. **Barbiturates, Sedatives, Tranquilizers**
8. **Inhalants**
9. **Nicotine/Tobacco**
10. **Anabolic Steroids**
11. **Designer Drugs**

ALCOHOL*

Alcohol is a colorless, volatile, and pungent liquid found in fermented liquors such as beer, wine, wine coolers, champagne, and liquors. Alcohol is a central nervous system depressant that appears in the bloodstream within 5 minutes after ingestion and reaches its highest blood-alcohol level in 30-60 minutes. It is transported through the bloodstream to all parts of the body. Alcohol use can have many damaging effects on all areas of a person's life. For example, alcohol is the primary cause of liver disease, nutritional deficiencies, and is related to half of all traffic fatalities and homicides in the United States; individuals with drinking problems have higher rates of divorce and suicide than the general population. Persons who abuse alcohol may become alcohol dependent.

Some Slang Terms

booze, juice, sauce, grog, piss

Extent of Use

The 1993 Surgeon General Report indicates that, of the 20 million young people in the USA:

- 10 million drink alcoholic beverages.
- 8 million drink weekly
- nearly 500,000 binge drink

Some Immediate Effects

irregular pulse
loss of inhibitions
flushing and dizziness
slow reactions
slurred speech
impaired motor ability/coordination
blurred vision
increased blood pressure
sudden mood swings
vomiting

Other Potential Immediate and Long-Term Effects

slow, confused thinking
impairment of memory & logical thinking
unconsciousness
impaired nervous system functions
altered moods
affects emotional and behavioral reactions
may cause family problems
sexual impotence
birth defects (if mother uses)
enlarged heart
vitamin deficiencies
skin problems
loss of muscle tissue
inflammation of the pancreas
damage to lining of stomach and small intestine
stomach and small intestine ulcers
frequent infections
tingling and loss of sensations in the hands and feet
heart and blood disorders
high risk for cancer
severe swelling of the liver
inflamed liver (hepatitis)
cirrhosis of the liver
cancer of the liver
lung disease
brain damage

When alcohol is mixed with other drugs, the effects may be intensified resulting in severe illness or death.

A Few Other Concerns

In 1993, an estimated 17,500 people were killed in alcohol-related auto crashes (occuring at a rate of one every 30 minutes); this was 44% of all traffic deaths.

Physical dependence upon alcohol means that alcohol has become part of a person's normal physical functioning. Physical dependence is characterized by withdrawal symptoms when alcohol use is suddenly discontinued. These include agitation, profuse sweating, nausea, vomiting, acute hallucinations (auditory and visual -- mostly paranoid), incoherent speech, tremulousness ("the shakes" -- usually occurring 12-24 hours after last drinking episode), and sometimes convulsive seizures

Use of alcohol during pregnancy may cause Fetal Alcohol Syndrome. FAS is one of three most prevalent birth defects and is the only one which is completely preventable. A child born with Fetal Alcohol Syndrome may have some of the following defects:

Physical Defects	*Mental Defects*
abnormal facial features	mental retardation
growth deficiencies	hyperactivity/restlessness
low birth weight	learning disabilities
heart defects	behavior problems
deformed joints	poor coordination
small head	delays in development

Alcohol stays in the fetus twice as long as in the mother and thus may have a very damaging effect.

For More Information

Additional information on this and related topics is available from the
National Drug Information Treatment and Referral Hotline
(800) 662-HELP(4357)

This agency supplies printed materials, information on treatment services in specific states, referrals for treatment, and other resources.

*Adapted from material provided by the National Institute on Drug Abuse, U.S. Department of Health and Human Services.

MARIJUANA*

Marijuana comes from the hemp plant and is smoked in cigarettes or pipes or eaten. The texture of marijuana may range from fine to coarse. The color may vary between grayish-green to greenish-brown. As use of marijuana increases, the tolerance level increases, and as a result, dependence is more likely.

Some Slang Terms

pot, grass, weed, mj, reefer, boo, broccoli, ace, joint, Columbian

Extent of Use

Marijuana is the most extensively used illegal drug in the United States. The 1993 National Household Survey on Drug Abuse reports that:

- 33.7% of those surveyed admitted to having tried marijuana at some point in their lifetime.
- 9% admitted to having used marijuana during the past year.
- 4.3% used the drug in the past month
- 2.4% used the drug at least once a week
- Of those 1993 seniors who were daily users, (9.6% of the sample), 53% began the pattern of use before the 10th grade.
- 3.1 million used the drug daily.

Some Immediate Effects

increased pulse rate
restlessness
excitement
increased appetite
impaired motor ability/coordination
impaired driving ability
altered perception
impairment of concentration/learning

Other Potential Immediate and Long-Term Effects

slow, confused thinking
impairment of memory & logical thinking
anxiety or panic
diarrhea/cramps
weight loss/gain
energy loss and apathy
impaired sex drive
suppressed effects on sperm
toxic effect on brain nerve cells
increased risk of lung cancer
risk of chronic bronchitis
respiratory diseases/cancer
impaired immune system
blood vessel blockage
hallucinations and psychotic episodes

The marijuana user may experience psychological and physical dependence on the drug, and when use is abruptly stopped, certain withdrawal symptoms will be experienced, such as nausea, insomnia, irritability, and anxiety.

A Few Other Concerns

Marijuana cigarettes contain more of the known carcinogen benzopyrene than tobacco cigarettes and more than 50-100% tar.

THC, the psychoactive ingredient in marijuana, is stored in the fat of the body and may harm the brain and body by causing cells to become toxic. Long-time users risk serious and premature memory disorders.

Psychologically, marijuana use may have an adverse effect on the emotional development and social relationships of the user due to apathy and pasivity (Amotivational Syndrome) and severe mood swings.

Marijuana smoking can adversely effect the reproductive system.

Marijuana use during pregnancy has been associated with diminished birth weight and the presence of physical and mental characteristics similar to fetal alcohol syndrome (facial deformities, heart defects, deformed joints, low birth weight, small head). Marijuana has also been found to cause tremors and startle response withdrawal symptoms in newborn children.

For More Information

Additional information on this and related topics is available from the
National Drug Information Treatment and Referral Hotline
(800) 662-HELP(4357)

This agency supplies printed materials, information on treatment services in specific states, referrals for treatment, and other resources.

*Adapted from material provided by the National Institute on Drug Abuse, U.S. Department of Health and Human Services.

COCAINE & CRACK*

Cocaine comes from coca leaves or is made synthetically. This drug acts as a stimulant to the central nervous system. It appears as a white powder substance which is inhaled, injected, freebased (smoked), or applied directly to the nasal membrane ("snorted") or gums. Cocaine causes the brain to release chemicals that give the user a tremendous "rush" or "high" and a sense of having experienced energy, power, and "pleasure." Effects of cocaine occur within the first few minutes, peak in 15-20 minutes and disappear in about 1 hour. The immediate effects are what make cocaine so highly addictive.

Crack is chemically altered cocaine formed into small, hard, white chunks. It is a central nervous system stimulant that is extremely addictive and deadlier than other forms of cocaine. Addict ion can occur in two to three weeks or less. Crack reaches the brain in less than 8 seconds and produces a"high" which peaks in 10-15 seconds and lasts only 15 minutes and is immediately followed by an intense "low."

Some Slang Terms

coke, C, crack, dust, snow, blow, flake, toot, nose candy, The Lady, dream

Extent of Use

Monitoring the Future Study data indicate *cocaine* use among high school seniors has been on a downward trend since its peak in 1985 but has remained level from 1992-1995. In 1995, 5% of 10th graders report having tried cocaine at least once, up from 4.3% in 1994; for 8th graders, the trend has been from 2.3% in 1991 to 3.6% in 1994 to 4.2% in 1995.

The 1993 National Household Survey on Drug Abuse reported that 11.3% of those surveyed (aged 12 and older) had used *cocaine*. Of these, .2% used cocaine once a week or more. 2.2% used in the past year and .6% used in the past month. One in every 40 seniors (2.6%) surveyed report having used *crack* and responses suggest that 8th graders have a softening of attitudes about the drug. For crack, 1.8% of those surveyed reported use; 5% reported using it in the last year; .2% reported using it in the past month; .6% were white; 2.0% were Hispanic; 3.4% were black. These substances are used by people from all socio-economic levels.

Some Effects

increased heart rate
  and breathing
increased blood pressure
weight loss
insomnia
twitching
rise in blood sugar levels
fever
pallor (paleness)
impotence

dilated pupils
nasal congestion
cold sweats
fatigue
constipation
nausea
headaches
blurred vision
tremors
possibly seizures

In addition, users of crack may experience

- chronic sore throat and hoarseness
- burning of the lips/tongue/throat
- respiratory problems such as
  congestion of the lungs, wheezing,
  and spitting up black phlegm
- suppressed desire for food and sex
- lung cancer
- blood vessel constriction
- heart attack
- brain seizures that can result
  in suffocation and stroke

Both cocaine and crack can lead to major behavioral and "personality" changes such as

- lying
- stealing
- lowered ambition
- argumentativeness/short temper
- denial of responsibility
- confusion and poor concentration
- increased number of accidents
- flattened and dulled emotions
- loss of interest in friends, family, other
  social contacts
- job problems
- sadness and depression
- loss of interest in appearance
- extreme paranoia
- schizophrenic-like psychosis with
  delusions and hallucinations

Withdrawal symptoms include extreme irritability, sluggishness, nausea, and disorganized thinking, paranoia, intense craving of the drug, physical problems.

A Few Other Concerns

Risk of contracting HIV/AIDS or hepatitis through shared needles and other diseases because of a reduction in the body's ability to resist and combat infection..

In 1992, cocaine, or cocaine in combination with other drugs, was directly related to 3,465 deaths. Among these 49.61% were male, 35.48% were female.

In 1992, there were approximately 119,843 emergency room episodes related to cocaine use. Of these 3.2% were 6-17 years old, 24.8% were 18-25, 39.5% were 26-34, 26.71% were 35 and older; 13.55% were white; 56.25% were black; 28.04% were Hispanic.

Use of cocaine and crack are associated with increased incidences of miscarriage, premature labor, and still births; fetal cell damage; pre-natal strokes due to fluctuations in blood pressure, kidney and respiratory ailments; and fetal addiction which can lead to painful and life threatening withdrawal. During withdrawal, babies are irritable, have poor ability to regulate their own body temperature and blood sugar and are at increased risk of having seizures and Sudden Infant Death Syndrome.

For More Information

Additional information on this and related topics is available from the
National Drug Information Treatment and Referral Hotline
(800) 662-HELP(4357)

This agency supplies printed materials, information on treatment services in specific states, referrals for treatment, and other resources.

*Adapted from material provided by the National Institute on Drug Abuse, U.S. Department of Health and Human Service.

HALLUCINOGENS*

Hallucinogens are manufactured or grown naturally and are sold illegally. Many are formed into a white powder. They have no taste and are found as tablets, capsules, tiny sheets of paper, or liquid. Well-known are PCP (phencyclidine), LSD (lysergic acid diethylamide), mescaline and peyote. Certain types of mushrooms and datura plants are also hallucinogens. These drugs are injected, "snorted," smoked, eaten or taken orally and produce radical changes in the mental state, involving distortions of reality (taste, smell, hearing, vision) and produce acute hallucinations. Effects may be experienced 15-30 minutes after use, may last up to 24 hours, and may affect the user in many different ways during any period of use.

Some Slang Terms

angel dust, loveboat, magic mushrooms, gold tops, acid, cubes, barrels, flats, window panes, microdots, purple haze, tickets, wedges

Extent of Use

The National Household Survey on Drug Use data indicate use of hallucinogens has been level since 1988. The 1993 survey found 8.7% (12 years and older) using hallucinogens, 1.2% used in the past year, .2% used in the past month, 10.1% of those who ever used were white, 5.9% were Hispanic, and 3.0% were black. The 1994 survey found 2.8% (12 years and older) report use of PCP at least once; lifetime use for those 12 through 17 was 1%. For LSD, the data indicate a .8% rate for past-year use of those age 12 and older; lifetime use for those 12 through 17 was 3.4%.

Monitoring the Future Study data indicate PCP use among high school seniors declined steadily from 7.0% in 1979 to 1.4% in 1991, but 1994 and 1995 data show a slight increase to 1.6 and 1.8 respectively. LSD use has remained relatively stable; in 1995, 11.7 percent of high school seniors reporting experimentation, and the annual prevalence rate was 8.4%.

Some Immediate Effects

a sense of estrangement
hallucinations (lights, colors))
intense awareness of stimuli
confusion/suspicion/panic due to loss of control
unpredictable, at times violent, behavior
emotional instability
increased heart rate and blood pressure
sleeplessness and tremors
sparse, mangled, incoherent speech
lack of muscular coordination
decreased awareness of touch and pain
convulsions

Other Potential Immediate and Long-Term Effects

brain damage
possible chromosome damage
mental confusion and depression
psychiatric complications
impaired memory
poor attention span
toxic level of tolerance
psychological dependence
convulsions
coma
suicide
death

Large doses are associated with frightening and disturbing experiences. Use can lead to dependency, but physical withdrawal symptoms are uncommon. Use of one hallucinogen can cause an increase in tolerance to other hallucinogens.

A Few Other Concerns

If high doses are used, unpleasant episodes ("bad trips") may occur which can be frightening and dangerous. Bad "trips" have been associated with serious emotional and behavioral reactions, including suicide. A person may a "flashback" -- re-experiencing the effects of a "trip", days, weeks, or years after use.

Hallucinogens may radically affect the brain, affecting personality and mental health. There is concern that the physical and mental damage may be irreversible for some people.

Some users manifest unpredictable, erratic, and violent behavior, which can lead to serious injuries and even death (drownings, burns, falls, automobile accidents). In 1991, hallucinogens were associated with over 8,000 hospital emergency room visits and over 100 deaths.

As with other drugs, there are pregnancy-related risks, including increased risk of spontaneous abortions and of congenital and chromosome damage.

For More Information

Additional information on this and related topics is available from the
National Drug Information Treatment and Referral Hotline
(800) 662-HELP(4357)

This agency supplies printed materials, information on treatment services in specific states, referrals for treatment, and other resources.

*Adapted from material provided by the National Institute on Drug Abuse, U.S. Department of Health and Human Services.

OPIATES (NARCOTICS)*

Opiates are habit-forming drugs that dull the senses, relieve pain, and induce sleep. Some forms of opiates are opium, morphine, heroin, and codeine. Some opiates come from a resin taken from the seed pod of the Asian poppy; others are synthesized or manufactured (e.g., meperidine -- trade name Demerol. Opiates may be in the form of dark brown chunks, or white or brownish powder which is usually smoked or eaten. Heroin can be a white or brownish powder which is usually dissolved in water (and usually "cut" with other substances such as sugar or quinine) and then injected. Other opiates come in a variety of forms including capsules, tablets, syrups, solutions, and suppositories. User experiences a sense of relaxation and a "rush" but soon may go "on the nod" -- going back and forth from feeling alert to drowsy. A tolerance to the drugs may occur if a person uses them over a period of time. A cross tolerance may also occur. This means that if a person uses one type of opiate, they will develop a tolerance to all opiates. Addiction to opiates such as heroin causes many dangerous physical and psychological effects.

Some Slang Terms

Codeine -- *school boy;*
Heroin -- *H, stuff, junk, horse, Harry, smack*
Morphine -- *M, white stuff, cube, morf, mud*

Extent of Use

Data are quite limited on use with school age youngsters. The Monitoring the Future Study provides data on heroin use. Trends show small increases from 1991 to 1994. Rates for lifetime use among 8th graders in 1994 was 2%, among 10th graders it was 1.5% and for 12th graders it was 1.2%. Annual and 30 day rates of use are lower (e.g., 30 day rates were .6% for 8th graders and .3% for 12th graders). Other sources of data suggest that heroin accounts for 90% of opiate abuse in the U.S.A.

Some Immediate Effects

decreased awareness
dilated pupils
restlessness
depression of respiration
nausea and vomiting
fluctuating between alertness and drowsiness

Effects last approximately 4 hours. However, with very large doses, the user cannot be awakened, pupils dilate, the skin becomes cold, moist, and bluish. Breathing slows down and death may occur. With any level of use, contaminated needles can cause hepatitis, abscesses, blood poisoning, and AIDS.

Other Potential Immediate and Long-Term Effects

physical dependence
psychological dependence
lethargy
indifference to environment/people
reduction of bowel movements
infections of the heart lining and valves
skin abscesses
congested lungs
possibly death

Because opiates are extremely addictive, withdrawal symptoms occur when a person stops or decreases their use (e.g., uneasiness, tremors, crying, diarrhea, weight loss, abdominal cramps, runny nose). Withdrawal symptoms begin within 24 hours after last use and may last up to 7-10 days. Withdrawal can be dangerous depending upon the amount of the drug the person used. Medical attention is strongly advised.

A Few Other Concerns

In 1992, the U.S. Dept. of Health and Human Services reported 49,899 emergency room episodes related to heroin, morphine, and codeine. Of these 6% involved people 18-25 years old, 12.3% involved people 26-34 years old, and 16.4% involved people 35 years and older; 7.6% were white, 15.1% were black, and 20.2% were Hispanic.

In 1992, there were 3,762 reported deaths due to heroin, morphine, and codeine.

Research has shown that nearly half of the women who are dependent on opiates suffer anemia, heart disease, diabetes, pneumonia, or hepatitis during pregnancy and childbirth. These women also experience more spontaneous abortions, breech deliveries, caesarean sections, premature births, stillbirths, and infants with withdrawal symptoms and who may die in infancy.

For More Information

Additional information on this and related topics is available from the
National Drug Information Treatment and Referral Hotline
(800) 662-HELP(4357)

This agency supplies printed materials, information on treatment services in specific states, referrals for treatment, and other resources.

*Adapted from material provided by the National Institute on Drug Abuse, U.S. Department of Health and Human Services.

STIMULANTS (AMPHETAMINES, METHAMPHETAMINE)*

Amphetamines (speed, uppers) are central nervous system stimulants. They are colorless and may be inhaled, injected, or swallowed. These drugs may be used medically to treat depression, obesity, and other conditions, but their therapeutic use is limited. Amphetamines are also used non-medically to avoid sleep, improve athletic performance, and counter the effects of depressant drugs.

Methamphetamines are synthetic amphetamines or stimulants that are produced and sold illegally in pill form, capsules, powder, and chunks. Two such synthetics are *crank* and *ice*. Crank refers to any form of methamphetamine. Ice is a crystallized smokeable chunk form that produces a more intense reaction than cocaine or speed. Ice appears clear and crystal-like and resembles frozen ice water. Methamphetamine is taken orally or intranasally (snorting the powder), by intravenous injection, and by smoking. These synthetics also stimulate the central nervous system, but with a greater effect than amphetamines. Immediately after inhalation or intravenous injection, the user experiences an intense sensation, called a "rush" or "flash," that lasts only a few minutes and is described as extremely pleasurable. Oral or intranasal use produces euphoria -- a high, but not a rush. The effects may last anywhere from 8 to 24 hours. Because methamphetamine elevates mood, people who experiment with it tend to use it with increasing frequency and in increasing doses, although this was not their original intent. Crank and ice are extremely addictive.

Some Slang Terms

Amphetamines -- *uppers, ups, wake ups, bennies, dexies, black beauties, jollies, speed*
Methamphetamine -- *speed, meth, chalk, ice, crystal, glass*

Extent of Use

In 1994, the Monitoring the Future Study found 15.7% of high school seniors had used stimulants at least once in their lifetimes (an increase from 15.4% in 1991) and 9.4% had used stimulants in 1994 (an increase from 8.2% in 1991). For 8th graders, the lifetime figure was 12.3% and use in 1994 was 7.9% (both increases over 1991). The findings also indicate that 3.4 percent of high school seniors had used crystal methamphetamine at least once in their lifetimes (an increase from 2.7 percent in 1990) and 1.8 percent had used crystal methamphetamine in 1994 (an increase from 1.3 percent in 1990).

Some Immediate Effects

increased heart rate
increased blood pressure
reduced appetite
dilated pupils
increased breathing rate

increased talkativeness
sense of well-being
actions become compulsive
  repetitive, less organized
  suspicious , self-conscious

increased aggressiveness
disturbed sleep
possibly depression
possibly hallucinations (visual, auditory)

With large doses:

fever and sweating
dry mouth
headache
blurred vision/dizziness

irregular heartbeat
tremors and other uncontrollable movements
loss of coordination
possible convulsions and collapse

Also possible are burst blood vessels in the brain, heart failure, or very high fever leading to death.

Other Potential Immediate and Long-Term Effects

- acne, sores
- malnutrition due to appetite suppression
- violence and aggression
- impaired speech
- increased susceptibility to illness due to poor diet, lack of sleep, unhealthy environment, or from IV injections
- use of other drugs to counter unwanted side effects of stimulants
- symptoms of paranoid schizophrenia and depression
- blockage of blood vessels
- damage to kidney/liver/lung/brain
- increasing tolerance and dependence

Because stimulants are addictive, withdrawal symptoms occur when a person stops or decreases their use (e.g., severe exhaustion, deep sleep lasting from 24 to 48 hours, psychotic reaction, extreme hunger, deep depression, anxiety reactions, long but disturbed sleep). Withdrawal can be dangerous. Methamphetamines cause a severe crash after the effects wear off. The crash, or low feeling is more intense and longer lasting than both speed and cocaine. The effects are not only long lasting, but continue to cause damage to the user long after use has stopped. Professional attention is advised.

A Few Other Concerns

Stimulants suppress appetite and give feelings of energy. Thus, they are sometimes abused by people trying to lose weight. But, because appetite is suppressed and decreased, a user may not get enough vitamins or minerals and may experience malnutrition, lose a dangerous amount of weight, or may become ill more often. When a person stops using stimulants, s/he experiences strong hunger. Abuse of amphetamines is not a safe nor effective way to lose weight.

Effects on society include accidents, drug-related crime, fires due to explosions from the illegal manufacture of methamphetamines, hazardous waste, among others.

Children born to methamphetamines users may have increased risk of child abuse and neglect.

It is possible for babies of mothers who use stimulants to be born with cardiac defects and other birth defects, to experience addiction and withdrawal, to manifest tremors, to cry for long periods, and to have difficulty bonding.

For More Information

Additional information on this and related topics is available from the
National Drug Information Treatment and Referral Hotline
(800) 662-HELP(4357)

This agency supplies printed materials, information on treatment services in specific states, referrals for treatment, and other resources.

---

*Adapted from material provided by the National Institute on Drug Abuse, U.S. Department of Health and Human Services.

BARBITURATES, SEDATIVES, AND TRANQUILIZERS*

Barbiturates, sedatives, and tranquilizers are depressants to the central nervous system and are used to calm, induce sleep, or decrease anxiety. They depress the effectiveness of the central nervous system which in turn slows the body down. They are sometimes referred to as sedative-hypnotics. Their effects range from calming down anxious people to promoting sleep -- depending on dosage. At high dosages, they may cause unconsciousness and even death. Usually they are sold in the form of multi-colored tablets and capsules, but they may be a liquid that is swallowed or injected, and sometimes they come in the form of suppositories.

> Barbiturates and benzodiazepines are two major categories of these drugs. Some well known barbiturates are secobarbital (Seconal), amobarbital (Maytal), and pentobarbital (Nembutal). Examples of benzodiazepines are diazepam (Valium), chlordiazepoxide (Librium), chlorazepate (Tranxene), alprazolam (Xanax), and flunitrazepam (Rohypnol).Rohypnol is the brand name of a sleeping pill marketed in Mexico, South America, Europe and Asia, but not in the U.S.A. It has been designated "the Quaalude of the '90s" in some media reports. During the past few years, there has been increasing abuse of Rohypnol, initially reported in Florida and Texas, but now becoming more widespread. A few similar drugs that don't fit into either of these groups are methaqualone (Quaalude, Sopor), ethchlorvynol (Placidyl), chloral hydrate (Noctec), mebrobamate (Miltown), and glutethimide (Doriden).

Tranquilizers are not a cure; they merely relieve the symptoms associated with certain problems. There are two types of tranquilizers: (1) major tranquilizers -- known as "anti-psychotics" and used for the treatment of mental illness and (2) minor tranquilizers -- used to decrease anxiety as well as induce sleep. Tranquilizers are prescribed to treat anxiety caused by stressors in an individual's environment and for insomnia; they also act as a general anesthetic.

Some Slang Terms

barbs, red devils, goof balls, yellow jackets, block busters,
pinks, reds and blues, Christmas trees, rainbows, double trouble, downers
Quaaludes are called *ludes, mandrakes, soaps, soapers*
Rohypnol is called *roacchies, La Roche, rope, rophies, roofies, ruffies.*

Extent of Use

The 1993 National Household Survey on Drug Abuse reported that of those surveyed 4.6% of people (12 and older) used tranquilizers, 1.2% used in the last year, .3% used in past month; 5.2% were white, 2.8% were Hispanic, 2.3% were black. With respect to students using in the past month, .9% of 8th graders had done so and 1.1% of 10th graders and 1.2% of 12th graders had done so.

In 1994, the Monitoring the Future Study found 6.6% of high school seniors had used tranquilizers at least once in their lifetimes (an decrease from 7.2% in 1991) and 3.7% had used them in 1994 (an increase from 3.6% in 1991). For 8th graders, the lifetime figure was 4.6% and use in 1994 was 2.4% (both increases over 1991).

Some Effects

The effects of any drug depend on (a) the amount taken at any one time, (b) the user's past drug experience, (c) the manner in which the drug is taken, and (d) the circumstances under which the drug is taken (the place, the user's psychological and emotional stability, the presence of other people, the simultaneous use of alcohol or other drugs, etc.).

Short-term effects

Appear rapidly after a single dose and disappear within a few hours or days. With barbiturates, a small dose may relieve anxiety and tension. A somewhat larger dose will, in a tranquil setting, usually induce sleep. An equivalent dose in a social setting, however, may produce effects similar to those of drunkenness -- a "high" feeling, slurred speech, staggering, slowed reactions, loss of inhibition, and intense emotions often expressed in an extreme and unpredictable manner. High doses characteristically produce slow, shallow, and irregular breathing, and can result in death from respiratory arrest.

> Non-medical users often start taking barbiturates at doses within a safe therapeutic range. As tolerance develops, however, they progressively increase their daily dose to many times the original. It is extremely important to note that in spite of acquiring tolerance to the intoxicating effects of barbiturates, the user develops no tolerance to the lethal action of the drug Therefore, high doses could produce fatal results even for tolerant abusers.

Taking barbiturates with other CNS depressants (e.g. alcohol; tranquillizers; such opioids as heroin, morphine, meperidine/Demerol, codeine, or methadone; and antihistamines -- found in cold, cough, and allergy remedies) can be extremely dangerous, even lethal.

> No one should operate a motor vehicle or engage in tasks requiring concentration and coordination while under the influence of any CNS depressant.

Long-term effects

These effects -- particularly of protracted high-dose abuse -- are not unlike a state of chronic inebriation. Symptoms include the impairment of memory and judgment; hostility, depression, or mood swings; chronic fatigue; and stimulation of preexisting emotional disorders, which may result in paranoia or thoughts of suicide. Although the prescribing of barbiturates has declined notably since the safer benzodiazepine tranquillizers were introduced, this group of drugs remains a significant contributor to drug-related deaths. They remain easily available to abusers through both licit and illicit sources.

> Because tolerance to the intoxicating effects of sedative/ hypnotics can develop rapidly with regular use, higher daily doses become necessary to achieve the desired effects. Taking more of the drug to compensate for tolerance, however, can lead to life-threatening complications. On one hand, there is the risk of death from overdose. On the other, when chronic and regular high-dose abuse has resulted in serious physical dependence, abrupt withdrawal can cause symptoms severe enough to cause death. For this reason, barbiturates are among the most dangerous of the widely abused drugs.

Physical dependence exists when the body has adapted to the presence of the drug, and withdrawal symptoms occur when its use is abruptly ended. These symptoms range in intensity from progressive restlessness, anxiety, insomnia, and irritability to delirium and convulsions in severe cases. Again, it must be stressed that physical dependence on barbiturates can be one of the most dangerous of all drug dependencies.

For More Information

Additional information on this and related topics is available from the
National Drug Information Treatment and Referral Hotline
(800) 662-HELP(4357)

This agency supplies printed materials, information on treatment services in specific states, referrals for treatment, and other resources.

*Adapted from material provided by the National Institute on Drug Abuse,
U.S. Department of Health and Human Services
and from the Addiction Research Foundation in Toronto, Canada

INHALANTS*

Inhalants are breathable chemical vapors that produce mind-altering effects. People don't think of inhalants as drugs because most of the products are commonplace items in homes and businesses. Young people are likely to abuse inhalants, in part, because they are so accessible and inexpensive. There are about 1400 products potentially usable as inhalants including volatile solvents such as gasoline, paint thinners, glue, cleaning solutions; aerosols; anesthetic agents; oil and grease dissolvers; and amyl, butyl, and isobutyl nitrites such as room fresheners. These all fall into two major categories: solvents and gases

Solvents come in the form of many products including degreasers and cleaning fluid (e.g. benzene, trichloroethane), gasoline (benzene, toluene, xylene), nail polish remover (e.g. acetone), lighter fluid (e.g. naphtha), model airplane glue and lacquer thinners (e.g. toluene, xylene), and plastic cement (e.g. hexane). They also are in some art and office supplies such as felt-tipped pens, correction fluids, and electronic contact cleaners. *Gases* also come in the form of many household/commercial products including butane lighters and propane tanks, whipping cream dispensers, cookware coating agents, refrigerant gases, spray paints, hair and deodorant sprays, fabric protector sprays, insecticides, some medications, medical anesthetic gases such as ether, halothane, and nitrous oxide and various forms of nitrates. Inhalants are ingested by "sniffing" or"snorting" (through the nose), "bagging" (inhaling fumes from a plastic bag), or "huffing" (stuffing an inhalant soaked rag into the mouth).

Some Slang Terms

laughing gas, rush, whippets, poppers, snappers

Extent of Use

Inhalants rank fourth in popularity behind alcohol, tobacco, and marijuana among young people. Junior high students seem to be among the most common-abusers. Statistics from a 1991-92 Pride USA survey show: inhalant use among 8th graders went from 5.1% in 1990-91 to 5.9% in 1991-92; 3.5% of 6th graders abused inhalants; 15% of the users said they used them daily; and 29% of users said they started before their 10th birthday. Nearly one in five (18%) high school seniors report having used inhalants. Trends from the Monitoring the Future Study show that the number of high school seniors reporting using inhalants during the past year has fluctuated between 6 and 9 percent since 1979. In the 1995 survey, the rate was 8% for seniors. Other surveys show a steady rise in use at all grades since 1991.

Some Effects

The effects of any drug depend on (a) the amount taken at any one time, (b) the user's past drug experience, (c) the manner in which the drug is taken, and (d) the circumstances under which the drug is taken (the place, the user's psychological and emotional stability, the presence of other people, the simultaneous use of alcohol or other drugs, etc.).

Short-term effects

Nearly all inhalants produce effects similar to anesthetics, which act to slow down body functions, yet the user feels stimulated. Inhaled vapors from solvents and propellants enter the bloodstream directly from the lungs and are then rapidly distributed to the brain and liver -- those organs with the largest blood supply. Most volatile hydrocarbons are fat-soluble, and are thus absorbed quickly into the central nervous system. Their action slows down breathing and heart rate. While some volatile hydrocarbons are metabolized and then excreted through the kidneys, many are eliminated from the body unchanged, primarily through the lungs. The complete elimination of volatile hydrocarbons may take some time, since they are released slowly from fatty tissues back into the blood.

Short-term effects appear soon after inhalation and disappear within a few hours. After inhaling there is a euphoric feeling, characterized by lightheadedness, exhilaration, and vivid fantasies. Nausea, drooling, sneezing and coughing, muscular incoordination, slow reflexes, and sensitivity to light may also occur. Some users' feelings of being very powerful may lead to reckless and bizarre behavior. Solvent abuse has been linked with such antisocial activities as dangerous driving, property damage, and theft.

> The effects of the first brief inhalation fade after several minutes. The experienced user, however, may prolong the effects for up to 12 hours, increasing the dose by concentrating the drug inside a plastic bag and continuing to sniff. For the majority of users, most effects disappear within an hour after sniffing is stopped, although hangovers and headaches may last several days.

Deep, repeated inhalation over short periods may result in a loss of control, culminating in hallucinations, unconsciousness, or seizures. A number of deaths have been associated with acute inhalant abuse, most prominently "sudden sniffing deaths" and suffocation. Sudden sniffing death, which typically follows strenuous exercise or undue stress after several deep inhalations, is caused by heart failure resulting from severely irregular heartbeat. Death by suffocation has occurred after users have fallen asleep or become unconscious with a plastic bag over nose and mouth. Some accidental deaths have been due to bizarre behavior caused by sniffing.

Long-term effects

> Appear following repeated use over a lengthy period and include such physical effects as pallor, thirst, weight loss, nosebleeds, bloodshot eyes, and sores on the nose and mouth. Some solvents, such as aromatic hydrocarbons (e.g. benzene), interfere with formation of blood cells in bone marrow, while others may impair liver and kidney function. Although these effects generally disappear when use is stopped, some cleaning fluids (trichloroethane) and aerosol propellants (fluorocarbons) can cause permanent liver and kidney damage. Alcohol use may compound the damage.

Behavioral symptoms in regular heavy sniffers include mental confusion, fatigue, depression, irritability, hostility, and paranoia. Signs of brain damage, including severely impaired mental function, lack of motor coordination, and tremors, have been noted in heavy users of toluene (found in contact cement). Gasoline sniffing may produce behavioral changes due to lead poisoning. The substances in solvents can pass through the placental barrier and enter the fetal bloodstream. However, except for evidence of birth defects among petrol inhalers, the evidence that use of other inhalants or solvents can damage the fetus is inconclusive. All drugs have some effects on the unborn child including chromosomal and fetal damage

> Regular inhalant use induces tolerance, which means increased doses are necessary to produce the same effects. After a year, for example, a regular glue sniffer may be using from eight to ten tubes of plastic cement to maintain the "high" originally achieved with a single tube. Psychological dependence on solvents -- where the need to keep taking them is a compulsion -- is fairly common. Clinicians report that youthful solvent abusers are among their most difficult clients to cure and a great many return to abusing the drugs. Physical dependence occurs when the body has adapted to the presence of inhalants and withdrawal symptoms occur if their use is stopped abruptly. Some chronic users, although by no means all, suffer chills, hallucinations, headaches, abdominal pains, or delirium tremens (DTs - the "shakes"). More often, however, solvent intoxication is followed by a brief period of excitement characterized by irritability, agitation, and increased heart rate.

For More Information

Additional information on this and related topics is available from the
National Drug Information Treatment and Referral Hotline
(800) 662-HELP(4357)

This agency supplies printed materials, information on treatment services in specific states, referrals for treatment, and other resources.

*Adapted from material provided by the National Institute on Drug Abuse,
U.S. Department of Health and Human Services
and from the Addiction Research Foundation in Toronto, Canada

BEST COPY AVAILABLE

NICOTINE/TOBACCO*

Nicotine is a substance found in tobacco. It is found in all tobacco products such as: cigarettes, pipe tobacco, chewing tobacco, and cigars. Cigarette smoking has been the most popular method of taking nicotine since the beginning of the 20th century. When a person smokes a tobacco product, they inhale the smoke which contains nicotine as well as over 500 chemicals. Nicotine is the drug in tobacco that causes addiction. Nicotine is physically and psychologically addictive. When a user is addicted to nicotine, they feel as if they need nicotine in order to function normally. The smoke from tobacco also contains tar which is damaging to the mouth, throat, and lungs. Nicotine reaches the brain within 10 seconds after intake. Nicotine is both a transient stimulant and a sedative to the central nervous system. The ingestion of nicotine results in an almost immediate "kick" because it causes a discharge of epinephrine from the adrenal cortex. This stimulates the central nervous system, as well as other endocrine glands, which causes a sudden release of glucose. Stimulation is then followed by depression and fatigue, leading the abuser to seek more nicotine.

Extent of Use

Tobacco (nicotine) use is the number one health problem in the U.S. The National Household Survey (1993) shows that about 60 million Americans -- including about one in five teenagers -- are current cigarette smokers, making nicotine one of the most heavily used addictive drugs. The findings report 71.2% of those surveyed have used nicotine, 29.4% used in the past year, 24.2% used in past month; 75.5% of ages 12 and up who reported using nicotine are white, 57.4% are Hispanic; 59.6% are black. Among youngsters, rates of those reporting having smoked cigarettes are 45.3% for 8th graders, 56.3% for 10th graders, 61.9% for 12th graders; regular smoking rates were 8.3% for 8th graders, 14.2% for 10th graders, and 19% for 12 graders. Since 1975, cigarettes have consistently been the substance that the greatest number of high school students use daily. In the 1995, Monitoring the Future Study, 19.1 percent of 8th-graders, 27.9 percent of 10th-graders, and 33.5 percent of 12th-graders had smoked cigarettes daily during the past month. More than 3 percent of 8th-graders, 8 percent of 10th- graders, and 12 percent of 12th- graders said they smoked half a pack of cigarettes or more per day.

Some Effects

Nicotine has been reported to reduce anxiety, and smokers report that they get calming effects from it. Nicotine is absorbed readily from tobacco smoke in the lungs. With regular use, levels of nicotine accumulate in the body during the day and persist overnight. Thus, daily cigarette smokers are exposed to the effects of nicotine for 24 hours each day. Nicotine taken in by cigarette smoking takes only seconds to reach the brain but has a direct effect on the body for up to 30 minutes. Cigarette smoke is primarily composed of a dozen gases (mainly carbon monoxide), nicotine, and tar. The tar in a cigarette, which varies from about 15 mg for a regular cigarette to 7 mg in a low-tar cigarette, exposes the user to a high expectancy rate of lung cancer, emphysema, and bronchial disorders. The carbon monoxide in the smoke increases the chance of cardiovascular diseases.

> Nicotine produces effects on mood as well as on the heart, lungs, stomach, neurotransmitters, and sympathetic and parasympathetic nervous systems. Short-term effects of nicotine in cigarette smoke can include sweating, vomiting, and throat irritation, diminished sense of smell and taste, frequent colds, and smoker's cough. Over time, more serious conditions develop -- including high blood pressure, blockage of blood vessels, depletion of vitamin C, reduction in the effectiveness of the immune

system, cancer of the mouth, throat, lungs, and upper respiratory tract, bronchitis and/or emphysema, stomach ulcers, weight loss, dryness and wrinkling of the skin, production of abnormal sperm in males. The effects of nicotine escalate bronchial and cardiovascular disorders -- chronic bronchitis and emphysema are common diseases among cigarette smokers. The risk of congestive heart failure also is increased by the effects of nicotine. The Environmental Protection Agency has concluded that secondhand smoke causes lung cancer and stroke in adults and greatly increases the risk of respiratory illnesses in children (only 12 percent of people diagnosed with lung cancer will live for 5 years). Cancers of the esophagus, mouth, lips, and larynx also are associated with cigarette smoking. Data suggest that nearly 450,000 deaths each year are related to smoking.

Women who smoke suffer from more reproductive tract infections, fertility and menstrual disorders, earlier menopause, and problems during pregnancy. They have a greater risk of premature detachment of the placenta. Once detachment has occurred, perinatal death rates also increase. This risk increases by 20% with every 1/2 pack of cigarettes smoked. Pregnant women who smoke cigarettes increase their risk of having stillborn or premature infants or infants with low birthweight. Women who smoke generally have earlier menopause. If women smoke cigarettes and also take oral contraceptives, they are more prone to cardiovascular and cerebrovascular diseases than are other smokers; this is especially true for women older than 30.

Because nicotine is so addictive, there are withdrawal symptoms that may occur when a person is not using this substance. These include a drop in pulse rate, drop in blood pressure, disturbance of sleep, slower reactions, tension, restlessness, depression, irritability , constipation, difficulty in concentration, and craving for tobacco.

For More Information

Additional information on this and related topics is available from the
National Drug Information Treatment and Referral Hotline
(800) 662-HELP(4357)

This agency supplies printed materials, information on treatment services in specific states, referrals for treatment, and other resources.

*Adapted from material provided by the National Institute on Drug Abuse,
U.S. Department of Health and Human Services

ANABOLIC STEROIDS*

Anabolic steroids are a form of the synthetic male hormone, testosterone, which is often used to increase muscle size and strength. The full name is androgenic (promoting masculine characteristics) anabolic (building) steroids (the class of drugs). These derivatives of testosterone promote the growth of skeletal muscle and increase lean body mass. Steroids are found in liquid or pill form.

> The anabolic steroid is medically used to increase body tissue. This drug also prevents the breakdown of tissue which certain diseases may cause. Certain steroids may also be used in some types of allergy medications. Over 80% of anabolic steroids are sold illegally through the black market and often are abused by athletes seeking to improve performance; others use steroids to improve physical appearance. The abuse of this drug may cause an increased, unnatural masculinity in the user and can cause many health problems as well as other side effects.

Steroids are taken orally or injected, and abusers take them typically in cycles of weeks or months, rather than continuously, in patterns called cycling. Cycling involves taking multiple doses of steroids over a specific period of time, stopping for a period, and starting again. In addition, users frequently combine several different types of steroids to maximize their effectiveness while minimizing negative effects, a process known as stacking.

Extent of Use

Because of growing professional and public concern over the misuse and abuse of steroids by adolescents and young adults, questions regarding anabolic steroid use were added to the Monitoring the Future survey in 1989 to afford a better understanding of the extent of the problem. From 1989 to 1993 there was a slight, gradual decline in lifetime and annual prevalence of anabolic steroid use among 8th-, 10th-, and 12th-graders. In 1994 and 1995 the levels remained about the same. Among the class of 1995, 2.3 percent of high school seniors had used anabolic steroids at least once in their lifetimes; 1.5 percent had used steroids in the past year. In 1995, 2.0 percent of 8th-graders and 2.0 percent of 10th-graders had used anabolic steroids at least once in their lifetimes, and 1.0 percent of 8th-graders and 1.2 percent of 10th-graders had used anabolic steroids within the past year. In addition to data regarding use, the 1994 survey reported students' attitudes toward steroid use: 67.6 percent of 8th-graders, 72.5 percent of 10th-graders, and 66.1 percent of seniors perceive great risk in trying steroids; 87.9 percent of 8th-graders, 90.8 percent of 10th-graders, and 91.9 percent of seniors say they disapprove of people who use steroids; 23.1 percent of 8th-graders, 33.6 percent of 10th-graders, and 42.9 percent of seniors feel it would be fairly or very easy for them to get steroids.

Some Effects

Reports indicate that use of anabolic steroids produces increases in lean muscle mass, strength, and ability to train longer and harder; but long-term, high-dose effects of steroid use are largely unknown. Many health hazards of short-term effects are reversible, but not all; and there is concern over possible psychiatric effects. In addition, people who inject steroids may use "dirty" needles and run the added risk of contracting or transmitting hepatitis or the virus (HIV) that leads to AIDS.

The major side effects of anabolic steroid use include liver tumors, jaundice, fluid retention, and high blood pressure; others are severe acne and trembling. Additional side effects include the following:

> For adolescents - growth halted prematurely through premature skeletal maturation and accelerated pubertal changes.
>
> For men - shrinking of the testicles, reduced sperm count, infertility, baldness, development of breasts.
>
> For women - growth of facial hair, changes in or cessation of the menstrual cycle, enlargement of the clitoris, deepened voice.

NIDA-supported research shows that aggression and other psychiatric side effects may result from anabolic steroid abuse. Many users report feeling good about themselves while on steroids, but researchers report that steroid abuse can cause wild mood swings including manic-like symptoms leading to violent, even homicidal, episodes. Depression often is seen when the drugs are stopped and may contribute to steroid dependence. Researchers reported also that users may suffer from paranoid jealousy, extreme irritability, delusions, and impaired judgment stemming from feelings of invincibility.

> Because steroids are addictive, withdrawal symptoms may occur when a person is not using steroids. These symptoms may include depression, loss of energy and appetite, insomnia, and manic-like symptoms.

For More Information

Additional information on this and related topics is available from the
National Drug Information Treatment and Referral Hotline
(800) 662-HELP(4357)

This agency supplies printed materials, information on treatment services in specific states, referrals for treatment, and other resources.

*Adapted from material provided by the National Institute on Drug Abuse,
U.S. Department of Health and Human Services

DESIGNER DRUGS*

A designer drug is an analog, a chemical compound that is similar in structure and effect to another drug of abuse but differs slightly in structure. Designer drugs are produced in clandestine laboratories to mimic the psychoactive effects of controlled drugs. The most commonly known types of synthetic analog drugs available through the illicit drug market include analogs of fentanyl and meperidine (both synthetic opioids), phencyclidine (PCP), and amphetamine and methamphetamine (which have hallucinogenic and stimulant properties). The street names of designer drugs vary according to time, place, and manufacturer, and they change frequently.

Fentanyl Analogs

Fentanyl was introduced in 1968 by a Belgium pharmaceutical company as a synthetic narcotic to be used as an analgesic in surgical procedures because of its minimal effect on the heart. In the early 1980s, clandestine laboratories began manufacturing derivatives that were pharmacologically similar to heroin and morphine. Usually injected, these analogs create addiction similar to that of the opiates and are marketed as potent heroin alternatives. The most commonly known analog is alpha- methylfentanyl, known on the streets as China White. Other fentanyl analogs on the street include synthetic heroin, Tango and Cash, and Goodfella.

> Fentanyl analogs are 80 to 1,000 times more potent than heroin, depending on how they are made, and are 200 times more potent than morphine. They are meant to duplicate the euphoric effects of heroin. Fentanyl analogs have a very rapid onset (1 to 4 minutes) and a short duration of action (approximately 30 to 90 minutes), which varies according to the particular drug. As with other narcotic analgesics, respiratory depression is the most significant acute toxic effect. Because of potency and quick onset, even a small dose can lead to sudden death.

China White which appeared in Orange County, California, in 1979, was the first synthetically produced fentanyl that resulted in overdose deaths. Between 1980 and 1985, China White and several other fentanyl analogs were responsible for 100 unintentional overdose deaths in California. In 1991, the analog Tango and Cash was implicated in at least 28 deaths, primarily in New York and other northeast areas. In 1992, China White was found to be the cause of death in 21 overdoses during 2 months in Philadelphia. Authorities report that a victim can die so suddenly from respiratory paralysis that the needle may still be present in the dead user's arm. The antidote naloxone may be used in an overdose situation to counter respiratory depression when the victim is found in time. Recent data indicate that smoking and sniffing are two means of ingestion that are becoming more popular -- perhaps because of the attempt on the part of users to avoid transmission of HIV/AIDS.

Meperidine Analogs

Meperidine (trade name Demerol) is a narcotic controlled under Schedule II of the CSA (meaning it has high potential for abuse but has a recognized medical use). Over the past decade, its illicit use has increased when heroin was scarce. MPPP (1-methyl-4-phenyl-4-propionoxypiperidine) and PEPAP (1-[2-phenylethyl]-4-acetyloxypiperdine) are two street used analogs often marketed as "new heroin." MPPP is popular because when it is injected, it produces a euphoria similar to heroin. MPTP (1-methyl-4-phenyl-1,2,3,6,-tetrahydro-pyridine), is a potent neurotoxin that can cause irreversible brain damage. Damage is manifested in a syndrome resembling severe Parkinsonism, which results in increased muscle tone, difficulty in moving and speaking, drooling, and cogwheel rigidity of the upper extremities. Tremor characteristically involves the proximal muscles and is more pronounced than the typical involuntary rest tremor occurring in Idiopathic Parkinsonism. MPTP was identified primarily in California, in the early 1980s.

Methamphetamine Analogs

Several dozen analogs of amphetamine and methamphetamine are hallucinogenic; many have been scheduled under the CSA. The methamphetamine analogs currently of concern include MDA (3,4-methylenedioxyamphetamine) and MDMA (3,4-methylenedioxy-methamphetamine).

> MDA, known on the street as "love drug," produces a heightened need for interpersonal relationships, and users report an increased need to talk to and be with other people. MDA became widely abused in the early 1980s on college campuses and by psychiatrists. Scientists find it damages the brain's serotonin neurons resulting in brain damage. Thus, it has been classified as a CSA Schedule I drug. Effects of MDA use resemble those of amphetamine intoxication: hyperactivity, hyperthermia, tachycardia, hypertension, and seizures.

MDMA, known on the streets as "ecstasy" or "Adam," is structurally similar to methamphetamine and mescaline. It stimulates the central nervous system and produces hallucinogenic effects. MDMA was first synthesized illegally in 1972 but was not widely abused until the 1980s. MDMA is closely related to the amphetamine family. It can result in a variety of acute psychiatric disturbances, including panic, anxiety, depression, and paranoid thinking. Physical symptoms include muscle tension, nausea, blurred vision, faintness, chills, and sweating. It also increases heart rate and blood pressure and has been shown to destroy serotonin-producing neurons in animals. These neurons play a direct role in regulating aggression, mood, sexual activity, sleep, and sensitivity to pain. MDMA has been reported to cause jaw clenching, tremor, and hallucinations. A small number of psychiatrists claim it is useful in enhancing psychotherapy. No evidence has been presented to document these few anecdotal reports.

> Both MDMA and MDA have been shown to be neurotoxic. In animal studies, the doses of MDA that produce neurotoxicity are only two or three times more than the minimum dose that produces psychotropic response. This suggests that individuals who are self-administering the drug may be getting a neurotoxic dose. Because of these effects and its abuse potential, MDMA was placed on Schedule I of the CSA on an emergency basis in July 1985. The Drug Enforcement Administration reports that MDMA is available in at least 21 states and Canada. It is especially popular with college students and young adults. According to NIDA's Monitoring the Future survey, 3.2 percent of young adults ages 19 through 28 and 2.0 percent of college students have tried MDMA at least once in their lifetimes.

PCP Analogs

PCP is registered under Schedule III of the CSA. Over the past 8 years, PCP analogs have been identified in confiscated street samples, but the use of these drugs is not widespread.

For More Information

Additional information on this and related topics is available from the
National Drug Information Treatment and Referral Hotline
(800) 662-HELP(4357)

This agency supplies printed materials, information on treatment services in specific states, referrals for treatment, and other resources.

*Adapted from material provided by the National Institute on Drug Abuse, U.S. Department of Health and Human Services

REMEMBER: IT IS A *DRUG* STORE!

It's surprising how many legal and easily accessible products can become dangerous substances of abuse. Beside the many household and industrial solvents and gases that become inhalants, newspapers and medical journals carry reports about youngsters dying from misuse of products sold over drugstore counters as health aids (such as asthma inhalers). Cough medicine is one such innocent appearing nonprescription product that young people have come to abuse in their pursuit of a "high." In the last few years, increasing reports suggest individuals are experiencing a host of serious negative drug effects from taking large doses of these antitussive medicines.

Dextromethorphan is the d-isomer of the opiate agonist levorphanol and is found in antitussive products such as Romilar and Robitussin. The *Physicians Desk Reference for Nonprescription Drugs* lists 53 different formulations that contain this drug. As an example of the problem, Murray and Brewerton (1993)* report the case of a 16 year old who was admitted to a psychiatric hospital because of self-destructive behavior. Robitussin cough medicine was among the drugs he indicated using regularly. "He reported that he and several of his friends often use this particular cough preparation as a substitute for alcohol and other drugs, and that he uses an average of three 8-oz bottles of Robitussin each week to make himself feel 'high and 'drunk'." The authors conclude with the caution: "Although usually thought to be nonaddictive, dextromethorphan produces a substance dependence syndrome, and physicians should be aware of its abuse potential, particularly by youths."

*S. Murray & T. Brewerton (1993). Abuse of over-the-counter dextromethorphan by teenagers. *Southern Medical Journal, 86,* 1151-1153.

Section IV

Substance Abuse Prevention and Treatment

In this section, you will find aids on

1. **Understanding the Nature and Scope of Model School Based Programs**
2. **Treatment of Ethnic Minority Substance Abusers**
3. **Treatment of Opiate Addiction**
4. **Treatment of Smoking Cessation**
5. **Guide to Helplines and Self-Help Resources**
6. **Guide to Useful Brochures and Pamphlets**

UNDERSTANDING THE NATURE AND SCOPE OF MODEL SCHOOL-BASED PROGRAMS

In her 1995 discussion of "Best Practices in Substance Abuse Prevention Programs," Kathleen McNamara analyzes the current state of the art and offers a way to group current activity.* She concludes that programs either have not been evaluated or have not yet produced the type of findings that demonstrate efficacy. At the same time, she views the growing knowledge base as useful in understanding (a) factors that should be addressed and (b) school-based programs that have potential for reducing or mitigating risk while promoting protection.

> McNamara categorizes four *methods*, with each directed toward three *audiences* in the school population.
>
>> The *methods* are (1) school policy initiatives, (2) education, (3) offering alternatives that encourage students to engage in activities incompatible with abuse, and (4) intervention, treatment, and support (e.g., screening, follow-up assessment, referral, counseling, support groups).
>>
>> She organizes the *audiences* around those who need primary, secondary, and tertiary prevention programs. That is, (1) those who have not yet used substances, (2) those who are seen as significantly at risk of becoming substance abusers, and (3) those who need immediate intervention because of the nature and scope of their substance use.

Along with so many others, McNamara stresses:

> Prevention methods are most effective when there is an appropriate "fit" between their message and the characteristics of their audiences in the school population. While an awareness campaign may be helpful in reducing the incidence of early first use of alcohol and other drugs, it is not likely to have an impact on students who are already engaged in regular use. Similarly, an educational program which features the testimony of a young adult or successful athlete recovering from addiction is not likely to address the needs of students who have never used drugs (and may, in fact, inadvertently promote such use) -- although it may be effective with students who have entered a dangerous phase of regular use. . . .
>
> Strategies for intervening on the circumstances or behavior of high-risk students address a range of personal and environmental factors. Traditional AOD (alcohol and other drugs) intervention programs focused on tertiary prevention, in which efforts were made to interrupt the development of harmful patterns of use. With growing understanding of the role of risk and protective factors, intervention efforts are now directed toward the amelioration of conditions creating *vulnerability* to AOD use, including academic failure, peer rejection, and poor coping skills. Intervention seeks to inhibit, reduce, or buffer the effects of risk factors by promoting skill development and creating an environment in which students can embrace normative values and behaviors such as school achievement, personal and social competence, and identification with positive role models and peer groups.

McNamara concludes that prevention programs are more likely to be effective when they

> involve multiple levels of influence, including peers, school personnel, and community resources (parents community leaders, media) in efforts to reduce the onset, use, and abuse of alcohol and other drugs . . . ;
>
> avoid a narrow focus on the variable of AOD use, in favor of approaches that address multiple risk factors at both individual and environmental levels . . . ;
>
> extend their scope beyond information giving and skill training to include strategies for promoting protective school environments and enhancing prosocial motivation.

---

*In A. Thomas & J. Grimes (Eds.), *Best Practices in School Psychology -- III*. Washington, DC: National Association for School Psychologists.

Adapted from "Best Practices in Substance Abuse Prevention Programs" by Kathleen McNamara (1995): In A. Thomas & J. Grimes (Eds.), *Best Practices in School Psychology*. Washington, DC: National Association for School Psychologists.

School-Based Programs for the *Primary* Prevention Audience

Purpose: Fostering attainment of characteristics which afford protection against substance abuse.

Efforts focus on

- promoting accurate perceptions of short-term consequences of substance use
- establishing coping skills and techniques to resist negative influence
- enhancing student performance and bonding to school
- forming positive peer associations
- establishing policy support and sanctions
- working with parents to assist development of effective family management skills
- working with community members to reduce student access to harmful substances.

School-Based Programs for the *Secondary* Prevention Audience

Purpose: Reducing or buffering the impact of risk factors.

Emphasis is on

- providing a more intensive focus on developing coping and resistance skills, coupled with efforts to arrest school failure,
- fostering caring relationships between students and adults
- increasing strategies to place school success and positive peer affiliation within reach of troubled and at-risk youth, including creation of opportunities for responsible and rewarding behavior
- extending interventions with families to focus on problem-solving and communication skills

School-Based Programs for the *Tertiary* Prevention Audience

Purpose: Interrupting and eliminating patterns of substance abuse.

In addition to the interventions recommended for the secondary prevention audience, efforts focus on:

- providing opportunities for students to learn and practice specific skills for achieving and maintaining abstinence and for coping with personal distress
- "reclaiming" this students by drawing them into the mainstream, thereby providing opportunities to establish or restore positive peer and adult affiliations and commitment to normative standards of behavior
- linking families with community-based resources and support networks of concerned parents
- working with law enforcement agencies to reduce availability and access to substances
- providing substance free activities and engaging students' interest and commitment to such activities

(cont.)

Providing Alternatives for all Audiences

In contrast to educational programs with their emphasis on information dissemination and skill development, providing alternatives is seen as addressing student motivation. The focus is on activities which students can value and expect to achieve satisfying outcomes through appropriate effort. Such activities also allow students to form caring, nurturing relationships with staff and peers. All this is seen as promoting protective factors, including prosocial bonding with peers and the school. Options programs range from special learning projects in the classroom to enrollment in magnet schools. Students may respond to the opportunity to assume a special status service role such as becoming a peer or cross-age tutor, counselor, mediator, or mentor. They may be attracted to working with staff in situations that allow them to move away from traditional teacher-student relationships (e.g., serving on a student-faculty committee). Alternatives allow students new ways to develop cognitive and interpersonal problem solving skills and enable staff to help these students develop new attitudes about school and teachers.

Unfortunately, as McNamara laments:

> In many schools, participation in alternatives is reserved for students who have demonstrated a capacity for responsible behavior. As a result, programs often address only the needs of the primary prevention audience, with the secondary and tertiary prevention audiences relegated to the role of recipient or beneficiary of service. This practice overlooks the power of alternatives for at-risk and troubled students, for whom participation offers an opportunity to achieve success while establishing bonds with positive peer groups and caring adults. . . . For students in the *primary prevention* audience, alternatives afford opportunities to expand and strengthen existing skills and prosocial motivation. Students in the *secondary prevention* audience are encouraged to participate in alternatives in order to establish and strengthen motives and skills to protect against and buffer the influence of risk factors. For the *tertiary prevention* audience, alternatives serve a "reclaiming" function, breaking patterns of failure, disengagement from school, and identification with deviant peer groups.

Intervention, Treatment, and Support

In addition to traditional individual and group counseling, Student Assistance Programs are often used for *secondary* and *tertiary prevention*. Such programs usually offer

- *Insight Classes* --a series of highly structured presentations, assignments, and discussions
- *Abstinence Support Groups* -- to support substance-free lifestyles
- *Concerned Persons Groups* -- to provide support and skill-training for students affected by the substance abuse of family members and friends
- *Issue-Focused Groups* -- to foster coping skills and provide emotional support.

About Substance Abuse Prevention *Curricula*

In a 1995 review, Linda Dusenbury and Mathea Falco state:*

> Quite a lot currently is known about the effective ingredients of promising prevention curricula. It is therefore discouraging to note that most of the money spent in this country on drug education has not been spent on promising programs. For example, a 1991 Government Accounting Office report estimated that a quarter of the $500 million spent annually on drug education was spent on curricula, but Hansen, Rose, and Dryfoos** report that most of that money is spent on aggressively marketed programs that have not been evaluated, or worse, have been shown not to work.
>
> DARE, QUEST, and Here's looking at You, 2000 are the three largest marketed programs. Other aggressively marketed programs include BABES, Project Charlie, Ombudsman, and Project Adventure. Of (these), only DARE has been adequately evaluated. And while DARE has been extremely successful at diffusion and dissemination ..., evaluations, including a recent met-analysis, suggest that DARE is not any more effective at reducing substance use behavior than standard curricular approaches.***

In contrast to such programs, Dusenbury and Falco identify the following as promising prevention curricula that have been developed by various projects:

Two developed for middle school students focus specifically on alcohol abuse

- *Alcohol Misuse Prevention Project* (Contact: Deborah Kloska, AMPS Project, 1016 Catherine St., Ann Arbor, MI 48104-1620 (313) 998-7255
- *Project Northland* (Contact: Cheryl Perry, University of Minnesota, Division of Epidemiology, School of Public Health, 1300 Second St., Suite 300, Minneapolis, MN 55455 (612) 624-4188

Others are described as focusing on prevention of gateway substance use:

- *Life Skills Training* -- for middle school students (Contact: Gilbert Botvin, Institute for Prevention Research, Cornell University Medical College, 411 E. 69th St., New York, NY, 10021 (212) 746-1270
- *Seattle Social Development Program* -- for elementary school students (Contact: Sally Christie, Developmental Research and Programs, 130 Nickerson St., Suite 107, Seattle, WA, 98109 (800) 736-2630 (includes a family component)
- *Project STAR* -- for middle school students (Contact: Luanne Rohrbach, USC/IPR, 1540 Alcazar St., Suite 210H, CHP Building, Los Angeles, CA, 90033 (213) 342-2686 (includes media, community, and family components)
- *Teenage Health Teaching Modules* -- for students in grades 7-12 (Contact: Lynn Watkins, Educational Development Center, 55 Chapel St., Newton, MA, 02160 (800) 225-4276 (described as a comprehensive health education program)

---

*L. Dusenbury & M. Falco (1995). Eleven components of effective drug abuse prevention curricula. *Journal of School Health, 65*, 420-425.

** W.B. Hansen, L.A. Rose, & J.G. Dryfoos (1993). *Causal factors interventions and policy considerations in school-based substance abuse prevention*. Report submitted to the Office of Technology Assessment, US Congress, Washington, DC.

***The authors site several reports from the same research group; the meta-analysis is in S. Ennett, N.S. Tobler, C.L. Ringwalt, & R.L. Flewelling (1994). How effective is Project DARE? A meta-analysis of outcome evaluations. *American Journal of Public Health, 84*.

What are the qualities found in more promising curricular approaches?

Dusenbury and Falco suggest such programs

(1) are *research-based/theory-driven* -- using an etiological perspective that considers risk and protective factors;

(2) use *developmentally appropriate information*; (Concrete, accurate, and relevant information with a here and now emphasis, e.g., short-term and negative social consequences, rather than extensive information about the types and effects of drugs.)

(3) offer *social resistance skills training* so students can recognize pressures to use substances and resist peer pressure while maintaining friendships. Such resistance training relies on

- *interactive teaching techniques* (such as role-playing, discussions, and small group activities)

and often is paired with

- *normative education* (which teaches about what most people do in relation to substance use)
- *broader-based skills training and comprehensive health education* (emphasizing such general social and personal skills as decision-making, goal-setting, stress management, communication, and assertiveness -- all of which are intended to promote social and academic competence and prevent many risky behaviors -- including substance use, sexual activity, and delinquent acts; such programs also may include family, community, and media components);

(4) are carried out by *teachers who are trained and supported* by program developers or substance abuse prevention experts;

(5) provide *adequate coverage and sufficient follow-up;*

(6) are *culturally sensitive*.

TREATMENT OF ETHNIC MINORITY SUBSTANCE ABUSERS

From: PJ Thurman, R. Swaim, & B. Plested, Intervention and treatment of ethnic minority substance abusers. In J.F. Aponte, R.Y. Rivers, & J. Wohl (Eds.), *Psychological Interventions and Cultural Diversity.* Boston: Allyn and Bacon.

Historically, the focus has been on assimilation -- integrating the various ethnic populations into the "American" way of life. Current thinking, however, focuses on efforts to help the dominant society understand the values and needs of the minority.

As guidelines for working in ethnic communities, the authors state:

> Development of culturally sensitive and appropriate treatment interventions requires a careful and thorough scrutiny of the specific population. A solid first step would be the recruitment of staff who are members of the targeted population or are familiar with the culture. At a minimum, recruited staff must be culturally sensitive-able to consider age, gender, socioeconomic status, access to opportunities, degree of acculturation, availability of social supports, cultural values and norms, spirituality, and family system. It is often beneficial to look within oneself and examine one's own values before confronting someone whose cultural values, traditions, and customs may be quite different.
>
> Because of the diversity between and within ethnic populations, it is also necessary to develop an understanding of the target group that resides in the service delivery area (Orlandi et al., 1992). Although it is difficult to generalize across groups, it is often helpful to review the literature. More important, local statistics related to substance abuse behaviors should be examined. Often this type of examination requires both an emotional and an intellectual commitment on the part of the service provider. It is important not to be caught in stereotypes, positive or negative. For example, all Native Americans are not noble warriors, nor are they all "drunken Indians."
>
> The need for multicultural consideration can extend to inclusion of diverse community members on advisory boards and task forces. These experts can help plan inservice training, service delivery, and policy format. They also have the opportunity to serve as role models for other community members while building a mutual understanding of the cultural issues between the participants. Such efforts also empower local ethnic communities to deal with the risk factors that can contribute to alcoholism and drug abuse.

With specific respect to substance abuse treatment, they state:

> Rogler, Malgady, Costantino, and Blumenthal (1987) identified three means of providing culturally sensitive mental health services to Hispanics, which also have application to substance abuse populations. These included increasing the accessibility of services through such means as use of bilingual/bicultural staff participation and development of treatment environments in which ethnic/cultural values and norms were honored. Another component of culturally sensitive treatment included matching ethnic clients with treatment modalities that are consonant with their perceived values, such as providing more behaviorally oriented or crisis intervention services rather than traditional insight-oriented therapy, particularly for less acculturated clients (Ruiz, 1981). A final approach directly incorporates cultural values into the therapeutic modality (e.g., utilizing cultural concepts like *machismo, respeto, or familism,* which are either restructured or used to therapeutic advantage).
>
> Delgado (1988) stresses the importance of both a culture-specific intake and culture-specific intervention in the treatment of alcohol abuse. The intake should consist of five guiding

principles: (1) development of an understanding of the role of alcohol and drugs within the family, (2) assessment of the degree of ethnic identity or acculturation, (3) language preference, (4) assessment of the adolescent's social network, and (5) previous treatment experience. Assessment of all of these dimensions should guide the intervention strategies and techniques used with the client. . . .

Panitz, McConchie, Sauber, and Fonseca (1983) emphasize the crucial element of family variables in both the etiology and the treatment of Latino alcoholism. Included in their recommendation is the important component of distinguishing between pathological and ideal *machismo*. The positive aspects of *machismo are* encouraged, in contrast to pathological *machismo* in which peer groups of males exert pressure on others to consume increasing amounts of alcohol to demonstrate one's masculinity.

Moncher, Holden, Schinke, and Palleja (1990) also suggest that the concept of *familism*, the complex interaction among Hispanic family members wherein identity and esteem are established, may be more applicable to Hispanic than to non-Hispanic families. They describe a complex and difficult case in which a Puerto Rican adolescent male was treated for substance abuse using multiple methods of structural family therapy, functional family therapy, cognitive-behavioral therapy, and case management. They indicate that use of *compadrazgo*, the extended kinship ties between godparents or *padrinos* and godchildren or *ahijados* can be utilized in which both family and extended family members can learn to provide reinforcement for positive behaviors such as the avoidance of substance abuse. . . .

Szapocznik et al. (1989) have developed a comprehensive prevention and intervention approach to Hispanic adolescent substance use and other problem behaviors, utilizing a strategic structural family systems approach. They identify three familial risk factors...: (1) current family maladaptive interactions (i.e., enmeshed or overinvolved maternal relationships combined with distant, excluded paternal relationships, as well as poor conflict resolution skills); (2) intergenerational conflict (i.e., the conflict that occurs developmentally as children move into adolescence); and (3) intercultural conflict (i.e., a problem that may be unique to migrating families in which youth acculturate more rapidly than adults, setting the stage for conflict to emerge over cultural values and behaviors). Family Effectiveness Training is aimed at correcting maladaptive family interactions and strengthening the family by increasing its flexibility in dealing with both developmental and cultural conflicts. Its psychoeducational format, which includes both didactic and experiential components, has been demonstrated to be superior to control conditions in improving family functioning and reducing problem behaviors in adolescents on the basis of both parental and self-report (Szapocznik et al., 1989).

Moore (1992) also supports the use of family therapy with African Americans. She noted that one cause for resistance in therapy may be familial. In the families' attempts to protect their children from treatment programs under the jurisdiction of Whites, Black parents sometimes participate in the maintenance of the problem. Family therapy is also congruent with the Native American community, in that many people have clan systems that are still active today. Extended family systems are important to this population, and inclusion of family in the therapeutic process is paramount to treatment success. The family system is also of primary importance to the psychosocial functioning of Pacific Islanders (Sue & Morishima, 1982). . . .

Although it was used for treatment of behavioral problems rather than substance use, one culturally based method for Puerto Rican children and adolescents incorporated the use of *cuentos* (Puerto Rican folktales) in which the characters served as therapeutic models (Malgady, Rogler, & Costantino, 1990). Adult hero and heroine role models were used with the adolescents. This culturally congruent treatment showed evidence of effectiveness in reducing anxiety and increasing social judgment in participants. Adaptations of this method could be made for use in substance abuse treatment. Freeman (1992) also utilizes storytelling with young African-American males. She uses family and cultural storytelling techniques to gain insight into engaging children and youth for prevention and treatment of substance abuse problems.

Spirituality is also a recognized tool in the treatment of ethnic minorities. In fact, a strong multidisciplinary team might include a spiritual leader reflective of the community culture.

BEST COPY AVAILABLE

Elders and youth might also be included recognizing the special roles that both play in the community. Likewise, medicine wheels, sweat lodges, talking circles, sundance preparation, and other traditional activities are used in some treatment centers to facilitate the healing process. Spiritual leaders, shamans, and medicine men or women are consulted by family members as well as by treatment professionals for inclusion in the therapeutic curriculum.

Knox (1985) argues that spirituality is a tool that can be used effectively in the treatment of the Black alcoholic and the family and should be explored in the assessment process. The sources of hope and strength should be examined, as well as the meaning of spirituality and the diversity of beliefs and practices of the family. Trotter and Chavira (1978) describes the role of *curanderos*, traditional folk healers, who have historically been consulted for the treatment of substance abuse problems, particularly alcohol abuse, among Latino families. *Curanderos* identify specific etiologies, and cures for alcohol abuse and make distinctions between problem drinking and alcohol addiction. Cures may consist of counseling, herbal cures, or administration of *Haba de San Ignacio*, a preparation similar to disulfiram, both of which produce nausea and vomiting when mixed with alcohol.

References

Delgado, M. (1988). Alcoholism treatment and Hispanic youth. *Journal of Drug Issues, 18*, 59-68.

Freeman, E. (11992). The use of storytellling techniques with young African American males: Implications for substance abuse prevention. *Journal of Intergroup Relations, 19*, 53-72.

Knox, D.H. (1985). Spirituality: A tool in the assessment and treatment of Black alcoholics and their families. *Alcoholism Treatment Quarterly, 2*, 31-44.

Malggady, R.G., Rogler, L.H., & Costantino, G. (1990). Culturally sensitive psychotherapy for Puerto Rican children and adolescents: A program of treatment outcome research. *Journal of Conusiting and Clinical Psychology, 58*, 704-712.

Moncher, M.S., Holden, G.W., Schinke, S.P., & Palleja, J. (1990). Behavioral family treatment of the substance abusing Hispanic adolescent. In E.L. Feindler & G.R. Kalfus (Eds.), *Adolescent behavior therapy handbook* (pp. 329-3349). New York: Springer.

Moore, S.E. (1992). Cultrual sensitivity treatment and research issues with Black adolescent drug users. *Child and Adolescent Social Work Journal, 9*, 249-260.

Orlandi, M.A., Weston, R., & Epstein, L.G. (1992). (Eds.), Cultural competence for evaluators: A guide for alcohol and other drug abuse prevention practitioners working with eethnic/racial communities. Rockville, MD: U.S. Department of Health and Human Services.

Panitz, Dd.R., McConchie, R.D., Sauber, S.R., & Fonseca, J.A. (1983). The role of *machismo* and the Hispanic family in the the etiology and treatment of alcoholism in Hispanic American males. *American Journal of Family Therapy, 11*, 31-42.

Rogler, L.H., Malgady, R.G., Costantino, G., & Blumenthal, R. (1987). What do culturally sensitive mental health services mean? The case of Hispanics. *American Psychologist, 42*, 565-570.

Ruiz, R. (1981). Cultural and historical perspectives in counseling Hispanics. In D.W. Sue (Ed.), *Counseling the culturally different: Theory and practice* (pp. 186-215). New York: Wiley.

Sue, S., & Morishima, J.K. (1982). *The mental health of Asian Americans*. San Francisco: Jossey-Bass.

Szapocznik, J., Santisteban, D., Rio, A., Perez-Vidal, A., Santisteban, D., & Kurtines, W.M. (1989). Family effcetiveness training: An intervention to prevent drug abuse and problem behaviors in Hispanic adolescents. *Hispanic Journal of Behaviorl Sciences, 11*, 4-27.

Trotter, R.C., & Chavira, J.A. (1978). Discovering new models for alcohol. Counseling in minority groups. In B. Velimirov (Ed.), *Modern medicine and medical anthropology in the United States-Mexico border population* (pp. 164-171). Washington, DC: Pan American Health Organization.

TREATMENT FOR OPIATE ADDICTION

There are four basic approaches to treating addiction to substances:

- detoxification (supervised withdrawal from substance dependence, either with or without medication) in a hospital or as an outpatient
- therapeutic communities where the addict lives in a highly structured drug-free environment and are encouraged to help themselves
- outpatient drug-free programs which emphasize various forms of counseling as the main treatment
- methadone maintenance which uses this substitute for heroin, on a daily basis, to help people lead productive lives while still in treatment.

About *methadone*:

> Methadone is a synthetic or manufactured drug that does not produce the same "high" as illegal drugs such as heroin, but does prevent withdrawal symptoms and craving for other opiates. It is used to help break the cycle of dependence on illegal drugs. Addicts in methadone maintenance programs are supposed also to receive counseling and, if needed, schooling and vocational training to help them toward a drug-free productive life.

About *narcotic antagonists*:

> Narcotic antagonists are drugs are used to block the "high" and other effects of opiates without creating physical dependency of producing a "high" of their own. They have been found extremely useful in treating opiate overdoses. They may be used as one facet of treating opiate dependence.

Adapted from material provided by the National Institute on Drug Abuse,
U.S. Department of Health and Human Services.

TREATMENT FOR SMOKING CESSATION*

Research suggests that smoking cessation should be a gradual process, because withdrawal symptoms are less severe in those who quit gradually than in those who quit all at once. Rates of relapse are highest in the first few weeks and months and diminish considerably after 3 months. The optimal treatment for smoking cessation includes behavioral therapy. Studies have shown that pharmacological treatment combined with psychological treatment, including psychological support and skill training to overcome high-risk situations, results in some of the highest long-term abstinence rates.

Nicotine chewing gum, available by prescription, is one medication approved by the Food and Drug Administration (FDA) for the treatment of nicotine dependence. Nicotine in this form acts as a nicotine replacement to help smokers quit the smoking habit. The success rates for smoking cessation treatment with nicotine chewing gum vary considerably across studies, but evidence suggests that it is a safe means of facilitating smoking cessation if chewed according to instructions and restricted to patients who are under medical supervision.

Another approach to smoking cessation is the nicotine transdermal patch, a skin patch that delivers a relatively constant amount of nicotine to the person wearing it. A research team at NIDA's Addiction Research Center studied the safety, mechanism of action, and abuse liability of the patch that was consequently approved by FDA. The nicotine patch can be obtained only with a doctor's prescription. Both nicotine gum and the nicotine patch are adjuncts to nicotine cessation programs and are used to help people achieve abstinence, reduce withdrawal symptoms, and prevent relapse while undergoing behavioral treatment.

For More Information

Additional information on this and related topics is available from the
National Drug Information Treatment and Referral Hotline
(800) 662-HELP(4357)

This agency supplies printed materials, information on treatment services in specific states, referrals for treatment, and other resources.

---

*Adapted from material provided by the National Institute on Drug Abuse, U.S. Department of Health and Human Services

Guide to Helplines and Self-Help Resources

Center for Substance Abuse Treatment (CSAT) Drug Abuse Information and Treatment Referral Hotline
An automated system which aids consumers in linking treatment within their communities. This system offers printed information on alcohol and other drugs, on treatment & hotlines within their home state, how to receive help for substance abuse problems and receive help for adolescents.
11426-28 Rockville Pike Suite 410
Rockville, MD 20852
1-800-662-HELP
1-800-66-AYUDA (Spanish speaking callers)

National Council on Alcoholism and Drug Dependence, Inc.
12 West 21st Street
New York, NY 10010
212-206-6770
1-800-NCA-CALL
Website: http://www.ncadd.org/

Center for Substance Abuse Prevention (CSAP)'s National Resource Center for the Prevention and Treatment of Alcohol, Tobacco, & Other Drug Abuse, and Mental Illness in Women
800-354-8824
703-836-8761

SHARE! (Self-Help and Recovery Exchange) - for Los Angeles County
5521 Grosvenor Blvd.
Los Angeles, CA 90066
310/305-8878
310/305-2671

Al-Anon/ Alateen Family Groups, Inc.
World Service Office
P.O. Box 862, Midtown Station
New York, NY 10018
1-800-344-2666
Website: http://solar.rtd.utk.edu/~al-anon/

Alcoholics Anonymous
World Service Office
475 Riverside Drive
New York, NY 10115
1-212-870-3400
Website: http://www.alcoholics-Anonymous.org/

Families Anonymous, Inc.
P.O. Box 528
Van Nuys, CA 91408
1-800-736-9805
1-818-989-7841

Nar-Anon Family Groups
P.O. Box 2562
Palos Verdes Peninsula, CA 90274
1-310-547-5800

Narcotics Anonymous (NA)
P.O. Box 999
Van Nuys, CA 91409
1-818-780-3951
Website: http://www.wsoinc.com/

National Cocaine Hotline
1-800-COCAINE

Cocaine Anonymous
3740 Overland Avenue, Suite G
Los Angeles, CA 90034
800-347-8998
Website: http://www.ca.org/

Marijuana Anonymous
P.O. Box 2912
Van Nuys, CA 91404
800-766-6779

National Domestic Violence Hotline
800-333-SAFE

Secular Organizations for Sobriety/Save Our Selves/SOS Internat'l Clearinghouse
5521 Grosvenor Boulevard
Los Angeles, CA 90066
310/821-8430

Guide to Useful Brochures and Pamphlets

National Clearinghouse for Alcohol and Drug Information (NCADI)

This center disseminates numerous brochures and pamphlets that provide much information on a variety of topics related to substance abuse. If you have access to the internet, you can retrieve these publications through their website: http://www.health.org/pubs/ . Or you may call them at 800-729-6686 to get free copies.

A list of brochures and pamphlets available from NCADI are as follows:

- *National Institute of Drug Abuse (NIDA) Capsules' Index*
  Provides information on topics such as updated statistics on drug abuse, profiles on various drugs of abuse, and special drug abuse issues concerning teens and young adults.
- *Tips for Teens*
  A series of colorful brochures designed to inform adolescents about the risks of alcohol, inhalants, smoking, crack/cocaine, marijuana, and hallucinogens and urges teens and their friends to stay drug-free. The brochures describe the physical and psychological symptoms of use, cite statistics, and provide resources for additional help and information.
- *Fact Sheets*
  Give factual information about marijuana, cigarette smoking, alcohol, methamphetamine, cocaine & crack cocaine, hallucinogens, and inhalants, as well as, about recognizing the signs of drug use and suggestions for getting help.
- *Alcohol Alerts*
  Highlight the relationship of alcohol to a host of relevant issues such as prevention, stress, drunk driving, AIDS, interactions with other medications, screening and assessment, minority groups, and so forth.
- *Making the Link Fact Sheets*
  A series of 1-page fact sheets which discuss alcohol and drug abuse in various settings such as schools, college, workplace, or in relation to other societal problems such as violence, suicide, mental health, impaired driving, etc.
- *By Our Own Hands*
  Consists of traditional and non-traditional prevention campaign materials especially intended for African American community. This packet includes a *community campaign brochure* which discusses key prevention concepts and messages and describes how to plan campaign events; *quick list 10 steps to a drug-free future (parent guide)* which is tailored to African American adults and offers suggestions on how to keep drugs out of the home, school, & community; *we have better things to do than drugs (poster and bumper stickers)* that feature African American youth engaged in a variety of fun and interesting activities such as sports, science, reading, art, and music.
- *Making Prevention Work Fact Sheets*
  Created to provide guidelines, assistance, & resources on how to establish and to operate action-oriented substance abuse prevention programs. These fact sheets are intended for adults and/or groups representing different sectors of the society such as media, business , parents, community leaders, schools, Hispanics, African-Americans, and the like.
- *Develop Your Own Publications*
  These are technical assistance bulletins developed by the Center for Substance Abuse Prevention (CSAP) featuring selected topics related to preventive work. Some examples of the topics are: Specific guidelines to assess cultural competence in program design, application and management; Avoiding common errors in developing prevention materials; Obtaining expert and gatekeeper reviews as a key step in developing prevention materials.

Addiction Research Foundation (ARF)

As one of its services, ARF publishes pamphlets that provide detailed fact sheets on a variety of substances of abuse, including their short and long-term effects, withdrawal symptoms, and potential for abuse. These pamphlets, which can be reproduced and are free of charge, can be downloaded through their website: http://www.arf.org/isd/pim/ . They can also be reached at 800-463-6273.

The series of fact sheets includes the following titles:

- Naltrexone
- Alcohol
- Amphetamines
- Barbiturates
- Benzodiazepines
- Caffeine
- Cannabis
- Cocaine
- Hallucinogens
- Inhalants
- LSD
- Opiates
- PCP
- Tobacco
- Tranquillizers and Sleeping Pills
- Alcohol, Other Drugs and Driving

Center for Substance Abuse Research (CESAR)

This center provides brochures which are intended to disseminate information on the nature and extent of substance abuse and related problems nationally. Aside from highlighting the physical and psychological effects of various drugs of abuse, the brochures report some recent findings from the Center's joint substance abuse research with the Center for Substance Abuse Treatment (CSAT).

The center's brochures can be accessed through their website: http://www.bsos.umd.edu/cesar/. The phone order number is 301/403-8329.

National Council on Alcoholism and Drug Dependence, Inc. (NCADD)

NCADD offers fact sheets, brochures, prevention materials for parents and youth, and posters that present valuable information about alcohol and other related issues such as signs of alcoholism; youth and alcohol; historical overview of alcholism as a disease; things to tell a child about drinking, and so forth. A complete list of these brochures and their prices can be obtained through their website: http://www.ncadd.org/pubs.html.

To order, please call 800/NCA-CALL or 212/206-6770.

Section V

Places to Go for More Information and Support

In this section you will find

(1) **Guide to Centers, Agencies, Advocacy Groups, and Internet Resources**

(2) **Some Consultation Cadre Members Who Can Help**

(3) **Guide to Additional References**

GUIDE TO CENTERS, AGENCIES, ADVOCACY GROUPS & INTERNET RESOURCES

Internet Resources

The following is a list of World Wide Web sites that offer information and resources related to substance abuse. This list is not comprehensive, but is meant to highlight some premier resources and serve as a beginning for your search.

The National Clearinghouse for Alcohol and Drug Information (NCADI)
Address: http://www.health.org/
Description: The NCADI is the largest repository of substance abuse treatment and prevention information in the country. This federal clearinghouse includes information from Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP), Center for Substance Abuse Treatment (CSAT), National Institute on Drug Abuse (NIDA), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). NCADI is the national resource for latest information on all aspects of this topic. It also designs, implements, and evaluates innovative knowledge transfer and communications strategies. NCADI's website allows electronic access to its Prevention Online (PREVLINE) which contains searchable databases on substance abuse prevention materials pertaining to alcohol, tobacco, and drugs.
Phone: 1-800-729-6686; 301-468-2600
P.O. Box 2345
Rockville, MD 20847-2345

The Substance Abuse and Mental Health Services Administration (SAMHSA)
Address: http://www.samhsa.gov/

Description: Offers updated information on SAMHSA's programs and servicesto assure that quality substance abuse and mental health services are available to the people who need them, as well as to ensure that prevention and treatment knowledge is used more effectively in the general health care system. This site also provides links to SAMHSA's other divisions such as Center for Mental Health Services (CMHS), Center for Substance Abuse Treatment (CSAT), Center for Substance Abuse Prevention (CSAP), Office of Applied Studies, Office of Managed Care, etc.
Phone: 301/443-8956

Center for Substance Abuse Research (CESAR)
Address: http://www.bsos.umd.edu/cesar/cesar.html
Description: CESAR is a research center within the College of Behavioral and Social Sciences, University of Maryland College Park. Its primary mission is to collect, analyze, and disseminate information on the nature and extent of substance abuse and related trends in a national scope. It also conducts policy-relevant research on specific initiatives to prevent, treat, and control substance abuse, and evaluates prevention and treatment programs. This website allows access to their electronic bulletin board, CESAR BOARD, which is one of the largest on-line sources of substance-abuse related information, as well as, summarized results of its research activities.
Phone: 301/403-8329
University of Maryland at College Park
4321 Hartwick Road, Suite 501
College Park, MD 20740

Addiction Research Foundation (ARF)
Address: http://www.arf.org/
Description: This website gives access to North America's largest facility combining research, treatment, and community action on substance abuse. As a major resource for alcohol and drug information, ARF's website provides online access to bibliographies, fact sheets, current issues and news summaries, Journal (ARF's newspaper) and its other products, programs and services that can be used in the community.
Phone: 1-800-463-6273
33 Russell Street
Toronto, Canada M5S 2S1

Project Cork Institute
Address: http://www.dartmouth.edu/dms/cork/
Description: This resource offers its online database of substance abuse information, the preparation of curriculum materials, and involvement in curriculum development efforts. The Project Cork database contains references (with abstracts) to over 13,000 journal articles, books, etc. on the subject of alcoholism and substance abuse. The file is updated quarterly and is available for searching, at no charge.
Phone: 603/646-3935
Fax: 603/646-2068

Partnership for a Drug-Free America: Drug Free Resource Net
Address: http://www.drugfreeamerica.org/
Description: This internet resource provides one of the largest database of drug information on the Web. It contains descriptions, drug paraphernalia, slang names, and pictures of different drugs of abuse. This site also contains helpful information for parents who need help.

Centers, Agencies & Advocacy Groups

Center for Substance Abuse Prevention (CSAP)
Division of Public Education &
Dissemination Center for Substance Abuse Prevention
SAMHSA Rockwall 2 Building, Room 800
5600 Fishers Lane
Rockville, MD 20857
301/443-0365
Website: http://www.samhsa.gov/csap/

Center for Substance Abuse Treatment (CSAT)
5600 Fishers Lane, Room 618
Rockville, MD 20857
301/443-5052

National Institute on Drug Abuse (NIDA)
5600 Fishers Lane, Room 10A03
Rockville, MD 20857
301/443-4577

U.S. Department of Education
Drug Planning and Outreach Staff
Office of Elementary and Secondary Education
400 Maryland Avenue, SW
Room 1073
Washington, DC 20202-6123
202/401-3030

National Institute on Alcohol Abuse & Alcoholism (NIAAA)
6000 Executive Boulevard - Wilco Bldg.
Bethesda, Maryland 20892-7003
Website: http://www.niaaa.nih.gov/

Center for Alcohol & Addiction Studies (CAAS)
Brown University, Box G-BH
Providence, RI 02912
Website: http://center.butler.brown.edu/

Join Together
441 Stuart St., 6th floor
Boston, MA 02116
617/437-1500
Website: http://www.jointogether.com/

Centers for Disease Control and Prevention (CDC)
National AIDS Clearinghouse
P.O. Box 6003
Rockville, MD 20849-6003
1-800-458-5231
Website: http://www.cdc.gov/

American Council for Drug Education
164 West 74th Street
New York, NY 10023
1-800-488-DRUG
212/758-8060

National Families in Action
2296 Henderson Mill Road, Suite 300
Atlanta, GA 30345
404/934-6364
Website: http://www.emory.edu/NFIA

Indian Health Service
Colorado River Service
Route 1, Box 12
Parker, AZ 85344
602/669-2137

Institute on Black Chemical Abuse Resource Center
2616 Nicollet Avenue, South
Minneapolis, MN 55407
612/871-7878

National Asian Pacific American Families Against Substance Abuse, Inc. (NAPAFASA)
420 E. Third St., Suite 909
Los Angeles, CA 90013-1647
213/617-8277

National Coalition of Hispanic Health Services Organization (COSSMHO)
1501 16th St., NW
Washington, DC 20036
202/387-5000
Website: http://www.cossmho.org/

Parents' Resource Institute for Drug Education, Inc. (PRIDE)
50 Hurt Plaza, Suite 210
Atlanta, GA 30303
404/577-4500
Website: http://www.prideusa.org/

Mothers Against Drunk Driving (MADD)
511 East John Carpenter Freeway, Suite 700
Irving, TX 75062
214/744-6233
800-GET-MADD

National Association for Children of Alcoholics (NACoA)
11426 Rockville Pike
Rockville, MD 20852
301/468-0985
Website: http://www.health.org/nacoa

National Association for Native American Children of Alcoholics
P.O. Box 18736
Seattle, WA 98118
206/467-7686

National Federation of Parents for Drug-Free Youth
11159B South Towne Square
St. Louis, MO 63123
314/845-1933

Students Against Driving Drunk (SADD)
200 Pleasant Street
Marlboro, MA 01752
508/481-3568

The National Organization on Fetal Alcohol Syndrome (FAS)
1819 H Street NW, Suite 750
Washington, D.C. 20006
202/785-4585
202/466-6456 (fax)
Website: http://www.nofas.org/

DARE America
P.O. Box 2090
Los Angeles, CA 90051
800-223-DARE

Children of Alcoholics Foundation, Inc.
P.O. Box 4185
Grand Central Station
New York, NY 10163-4185
212/754-0656
800-359-COAF

Department of Education Regional Training Centers:

Midwest Regional Center for Drug-Free Schools and Communities
1990 Spring Road, 3rd Floor
Oakbrook, IL 60521
708/571-4710

Northeast Regional Center for Drug-Free Schools and Communities Evaluation & Dissemination
12 Overtone Avenue
Sayville, NY 11782
516/589-7022

Southeast Regional Center for Drug-Free Schools & Communities
Speceriran Office Plaza, Suite 350
University of Louisville
Louisville, KY 40292
502/588-0052

Southwest Regional Center for Drug-Free Schools & Communities
University of Oklahoma
555 Constitution Avenue
Norman, OK 73037

Western Center for Drug-Free Schools & Communities
Northwest Regional Education Laboratory
101 SW Main Street, Suite 500
Portland, OR 97204-3212
800-547-6339; 503/275-9500
503/275-9489 (fax)
Website: http://www.nwrel.org/

Substance Abuse
Consultation Cadre List:

Note: Listing is alphabetized by Region and State as an aid so you can find and network with resources closest to you.

Our list of professionals is growing daily. Here are a few names as a beginning aid.

Center States

Iowa

Arthur Carder
Executive Director
Heartland Center
320 Tucker Building
Clinton, IA 52732
Phone: 319/243-5633
Fax: 319/243-9567

Michigan

Nancy Adadow Gray
Director, Family Counseling/Community
Mental Health Services
A.C.C.E.S.S.
2601 Saulino Court
Dearborn, MI 48120
Phone: 313/843-2844
Fax: 313/842-5150

Maria Jaramillo
Clinical Services Department Head
Latino Family Services
3815 W. Fort Street
Detroit, MI 48216
Phone: 313/841-7380
Fax: 313/841-3730

Minnesota

Elizabeth Latts
Information Specialist
National Center for Youth With Disabilities
Adol. Health Program-University of MN
Box 721, 420 Delaware Street S.E.
Minneapolis, MN 55455
Phone: 612/626-2401

Missouri

John Heeney
Assistant to Director
National Federation of State High School
Association
11724 NW Plaza Circle
P.O. Box 20626
Kansas City, MO 64195-0626
Phone: 816/464-5400
Fax: 816/464-5571
Email: JohnHeen@Aol.com

Ohio

Dianne Herman
Director, Children and Youth Services
South Community Inc.
349 West First Street
Dayton, OH 45402
Phone: 513/228-0162
Fax: 513/228-0553

East

Connecticut

Thomas Guilotta
CEO
Child & Family Agency
255 Hempstead Street
New London, CT 06320
Phone: 860/443-2896
Fax: 860/442-5909
Email: tpgullotta@aol.com

District of Columbia

Ronda Talley
425 Eighth Street, NW, #645
Washington, DC 20004
Phone: 202/393-0658
Fax: 202/393-5864
Email: rct.apa@email.apa.org

East (cont.)

Delaware

Marvis Hollowell-Clark
Coordinator
VNA Glasgow High School Wellness Center
1901 S. College Ave
Newark, DE 19702
Phone: 302/369-1501
Fax: 302/369-1503

Deanna Mears Pandya
Mental Health Counselor
VNA Wellness Center
1901 S. College Avenue
Newark, DE 19702
Phone: 302/369-1501
Fax: 302/369-1503

Maryland

Kristin Langlykke
Maternal and Child Health Bureau
Office of Adol. Health
5600 Fisher Lane
Rockville, MD 20857
Phone: 301/443-4026
Email: ncemch01@gumedlib.dml.georgetown.edu

Maine

Ellen Bowman
LCPC-Clinical Counselor
Maranacook Community School-Student
P.O. Box 177
Readfield, ME 04355
Phone: 207/685-3041

Michel Lahti
Project Coordinator
School-Linked Mental Health Services Project
Center for Public Sector Innovation - U of Southern Maine
295 Water Street
Augusta, ME 04333
Phone: 207-626-5274
Fax: 207-626-5210
Email: michel.lahti@state.me.us

New Jersey

Celeste Andriot
Director, Community Health Services
Division of Family Health Services
New Jersey Department of Health
363 W. State Street, CN 364
Trenton, NJ 08625-0364
Phone: 609/633-3666
Fax: 609/292-3580

New York

Laura Perry
Public Education Assistant
NY State Office of Alcoholism and Substance Abuse
1450 Western Avenue
Albany, NY 12203-3526
Phone: 518/473-3460
Email: perryl@emi.com

Pennsylvania

Steven Pfeiffer
Director, Behavioral Health Services
Genesis Health Ventures
Div. of Managed Care
312 West State Street
Kennett Square, PA 19348
Phone: 610/444-1520

Patricia Welle
Student Services Coordinator
School District of the City of Allentown
31 South Penn Street
P.O. Box 328
Alllentown, PA 18105
Phone: 610/821-2619
Fax: 610/821-2618

Rhode Island

Robert F. Wooler
Executive Director
RI Youth Guidance Center, Inc.
82 Pond Street
Pawtucket, RI 02860
Phone: 401/725-0450

Vermont

Brenda Bean
Program Development Specialist
Dept. of Dev. & Mental Health Services
103 South Main Street
Waterbury, VT 05671
Phone: 802/241-2630
Fax: 802/241-3052
Email: brendab@dmh.state.vt.us

Northwest

Idaho

Julie Johnson
School Psychologist
Moscow (Idaho) School District
410 East Third Street
Moscow, ID 83843
Phone: 208/882-1120
Fax: 208/883-4440

Montana

Judith E. Birch
Guidance Specialist
Office of Public Instruction
State Capitol, Rm 106
P.O. Box 202501
Helena, MT 59620-2501
Phone: 406/444-5663
Fax: 406/444-3924
Email: JBirch@OPI.MT.GOV

Washington

Rosie Moore
Mental Health Counselor
SWYFS/Chief Seattle High School
2600 SW Thistle Avenue
Seattle, WA 98126
Phone: 206/938-1360
Fax: 206/281-6704

Nancy N. Sutherland
School Nurse
Edmonds School District
20420 68th Avenue West
Lynnwood, WA 98036
Phone: 206/670-7325
Fax: 206/670-7182

Eric Trupin
Acting Director
Child & Adolescent Psychiatry
Children's Hospital & Medical Center
4800 Sand Point Way NE; CH-13
Seattle, WA 98105
Phone: 206/526-2000Georgia

Southeast

Georgia

Peter A. Cortese
Chief Program Development and Services Branch
Center for Disease Control and Prevention
Division of Adolescent and School Health
4770 Buford Highway, N.E., MS-K31
Atlanta, GA 30341-3724
Phone: 404/488-5365
Fax: 404/488-5972
Email: Pac2@ccdaSH1.EM.CDC.GOV

Louisiana

Dean Frost
Director, Bureau of Student Services
Louisiana State Department of Education
P.O. Box 94064
Baton Rouge, LA 70804
Phone: 504/342-3480
Fax: 504/342-6887

Sandra Simien
BCSW, Clinic Director
Eden Park School Based Health Clinic
2550 Bogan Walk
Baton Rouge, LA 70802
Phone: 504/336-1885

North Carolina

Sherry Jones
Assertive Outreach Counselor
Roanoke-Chowan Human Service Center
Rt. 3 Box 22A
Ahoskie, NC 27910
Phone: 919/332-4137

Barbara McWilliams
School Social Worker
Pinecrest High School
P.O. Box 1259
South Pines, NC 28388
Phone: 910/692-6554
Fax: 910/692-0606

Southwest

California

Martin Anderson
Director
Adolescent Medicine
UCLA Department of Pediatrics
10833 Le Conte Avenue, 12-476 MDCC
Los Angeles, CA 90095-1752
Phone: 310/825-5744
Fax: 310/206-8430
Email: P11676@mvs.medctr.ucla.edu

Celia Ayala
Director
Los Angeles County Office of Education
9300 Imperial Highway
Downey, CA 90242-2890
Phone: 310/922-6319
Fax: 310/922-6699
Email: ayala_celia@lacoe.edu

Bonny Beach
Lead Counselor
Fallbrook Union Elementary School District
Student Assistant Program
P.O. Box 698; 321 Iowa Street
Fallbrook, CA 92028
Phone: 619/723-7062
Fax: 619/723-3083

Beverly Bradley
2073 Wilbur Avenue
San Diego, CA 92109
Phone: 619/272-7164
Fax: 619/294-2146
Email: bevbradley@aol.com

Lois Coleman-Lang
Coordinator of Health Services
Tracy Public Schools
315 East 11th Street
Tracy, CA 95376
Phone: 209/831-5036
Fax: 209/836-3689

Kelly Corey
Regional Director of Business Dev.
Provo Canyon School
P.O. Box 892292
Temecula, CA 92589-2292
Phone: 909/694-9462
Fax: 909/694-9472

Alfredo Crespo
Psychologist
San Fernando Valley Child Guidance Clinic
9650 Zelzah Ave.
Northridge, CA 91325
Phone: 818/506-1348
Fax: 818/998-2726

Mike Furlong
Associate Professor
Graduate School of Education
University of California, Santa Barbara
Santa Barbara, CA 93106-9490
Phone: 805/893-3383
Fax: 805/893-7521
Email: mfurlong@edstar.gse.ucsb.edu

Mechele Haggard
Coordinator
Teenage Program
595 Center Avenue, Suite 120
Martinez, CA 94553
Phone: 510/313-6255
Fax: 510/313-6029
Email: MecheleSH@aol.com

John Hatakeyama
Deputy Director
Children and Youth Services Bureau
Department of Mental Health
505 S. Virgil Avenue
Los Angeles, CA 90020
Phone: 213/738-2147
Fax: 213/386-5282

Janice Jetton
Pediatric/Adolescent Nurse Practitioner
Newport-Mesa School District
1982 Port Locksleigh Place
Newport Beach, CA 92660
Phone: 714/640-1977
Fax: 714/640-0848

Michael Pines
Consultant
Div. of Career & Family Servs. L A Cnty. Office of Ed.
9300 Imperial Highway
Downey, CA 90242-2890
Phone: 310/940-1683
Fax: 310/940-1877
Email: pines_michael@mssmtp.lacoe.edu

California (cont.)

Marcel Soriano
Associate Professor
Division of Administration and Counseling
California State University, Los Angeles
5151 State University Drive
Los Angeles, CA 90032-8141
Phone: 213/343-4381
Fax: 213/343-4252
Email: msorian@calstatela.edu

Colorado

William Bane
Program Administrator
Colorado Department of Human Services
Mental Health Services
3520 W. Oxford Avenue
Denver, CO 80236
Phone: 303/762-4076
Fax: 303/762-4373

Hawaii

Harvey Lee
Program Specialist
Pacific Region Educational Laboratory
828 Fort Street Mall, Suite 500
Honolulu, HI 96813-4321
Phone: 808/533-7599

Candice Radner
Planner, Community Adolescent Program
Hawaii State Department of Health
School Health Services Branch
741-A Sunset Avenue
Honolulu, HI 96816
Phone: 808/733-8339
Fax: 808/733-9078

New Mexico

Peggy Gutjahr
Health Services Coordinator
Belen Consolidated Schools
520 North Main Street
Belen, NM 87002
Phone: 505/864-4466
Fax: 505/864-2231

Texas

Susan Henderson-Fuller
Mental Health Coordinator
Brownsville Community Health Center
2137 East 22nd Street
Brownsville, TX 78520

GUIDE TO ADDITIONAL REFERENCES:
Substance Abuse

I. Theory and Research

Prevention of substance abuse and related disorders in childhood and adolescence: A developmentally based, comprehensive ecological approach.
R. D. Felner, M. M. Silverman, & R. Adix (1991). *Family Community Health, 14* (3), 12-22.

Drug and alcohol attitudes and usage among elementary and secondary students.
G.P. Fournet, R.E. Estes, G.L. Martin, E.D. Robertson, & J. S. McCrary (1990). *Journal of Alcohol and Drug Education*, *35*(3), 81-92.

Preventing adolescent drug use: From theory to practice.
E. N. Goplerud (1991). Rockville, MD: Center for Substance Prevention (available from the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847-2345, 800-729-6686.)

The effects of alcohol abuse on the health of adolescents.
A.M. Arria, R.E. Tarter, & D.H. Van Thiel (1991). *Alcohol Health and Research World, 15*(1), 52-57.

Adolescent alcohol decisions
B. Fischhoff & M.J. Quadrel (1991). *Adolescent Health and Research World, 15*(1), 43-51.

Fostering resiliency in kids: Protective factors in the family, school, and community.
B. Benard (1991). Portland, OR: Northwest Regional Educational Laboratory.

II. School-Based Prevention Model Programs

Effective school-based substance abuse prevention programs.
N. L. Hickin & N. J. Christenberry (1993). Arkansas. (ERIC Document Reproduction Service No. ED381412*.)

Developing a substance abuse prevention program for at-risk elementary school students.
L. Schwartzkopf (1994). Florida. (ERIC Document Reproduction Service No. ED377435*.)

---

* To get a copy of an ERIC document, please contact ERIC Clearinghouse at 800-LET-ERIC for ordering and price information.

Tools for prevention: Building healthy youths. A training program for: School counselors, ,school nurses, school psychologists. Trainer manual.
M. P. Kohler & C. B. Collins, Jr. (1995). Alabama. (ERIC Document Reproduction Service No. ED387764*.).

Tools for prevention: Buidling healthy youths. A training program for: School counselors, school nurses, school psychologists. Participant manual.
M. P. Kohler & C. B. Collins, Jr. (1995). Alabama. (ERIC Document Reproduction Service No. ED387763*.)

At-risk youth in crisis: A handbook for collaboration between schools and social services. Volume 4.
(1991). Eugene, OR: Linn-Benton Educational Services. (ERIC Document Reproduction Service No. ED332308*.)

Combatting drug abuse: What you should know before designing a program for your school. Technical assistance bulletin no. 6.
(1992). Chicago, IL: American Bar Association: Special Committee on Youth Education for Citizenship. (ERIC Document Reproduction Service No. ED344825*).

Organizationl guidelines for establishing a core team to deal with alcohol and drug abuse: In a high school.
T. G. Sarnecki (1992). Florida. (ERIC Document Reproduction Service No. ED346370*).

Best practices in substance abuse prevention programs.
K. M. McNamara (1995). In: *Best Practices in School Psychology - III.* A. Thomas & J. Grimes (Eds.). Washington, D.C.: The National Association of School Psychologists.

School-based substance abuse prevention: Review of the state of the art in curriculum, 1980-1990.
W. B. Hansen (1992). *Health Education Research, 7*(3), 403-430.

Eleven components of effective drug abuse prevention curricula.
L. Dusenbury & M. Falco (1995). *Journal of School Health, 65*(10), 420-425.

School-community partnership.
J.H. Ebeling (March/April 1991). *Student Assistance Journal* (available from the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847-2345, 800-729-6686.)

---

* To get a copy of an ERIC document, please contact ERIC Clearinghouse at 800-LET-ERIC for ordering and price information.

Sharing your success: Summaries of successful programs and strategies supporting drug-free schools and communities (first edition).
(1991). Portland, OR: Northwest Regional Educational Laboratory.

Families and schools together (FAST): Prevention program that works.
L. McDonald (1991). *Family Resource Coalition Report, 10*(3). (available from Lynn McDonald, Ph.D., Family Service Inc., 128 East Olin Avenue, Suite 100, Madison, WI 53713.)

Success stories '94: A guide to safe, disciplined, and drug-free schools.
(1994). Washington, D.C. : U. S. Department of Education.

III. Community-Based Prevention Model Programs

Reaching and retaining high risk youth and their parents in prevention programs.
H. Resnick & M. Wojcicki (1991). In: *Preventing Adolescent Drug Use: From Theory to Practice. Monograph No. 8,* E. N. Goplerud (Ed.). Rockville, MD: Center for Subtance Abuse Prevention (available from the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847-2345, 800-729-6686.)

Programs for change: A realistic look at the nation's potential for preventing substance involvement among high-risk youth.
R. P. Lorian & J. G. Ross (1992). *Journal of Community Psychology*, 3-9.

Prevention plus II: Tools for creating and sustaining a drug-free community.
(1991). Rockville, MD: Center for Substance Abuse Prevention.(available from the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847-2345, 800-729-6686.)

The future by design: A community framework for preventing alcohol and other drug problems through a systems approach.
(1991). Rockville, MD: Center for Substance Abuse Prevention. (available from the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847-2345, 800-729-6686.)

Programs for change: Office for Substance Abuse Prevention demonstration models.
R.P. Lorion & J.G. Ross (Eds.) (1992). *Journal of Community Psychology, OSAP Special Issue.*

---

* To get a copy of an ERIC document, please contact ERIC Clearinghouse at 800-LET-ERIC for ordering and price information.

OSAP Technical Report-1: Breaking new ground for youth at risk: Program summaries. (1992). Rockville, MD: Office of Substance Abuse Prevention. (available from the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847-2345, 800-729-6686.)

IV. Specific Populations

Rural communities: Prevention resource guide A. Lane (1991). Rockville, MD: Alcohol, Drug Abuse, and Mental Health Administration (DHHS/PHS). Office for Substance Abuse Prevention. (ERIC Document Reproduction Service No. ED344710*).

Rural drug abuse prevention: Establishing needs and implementing programs. J. A. Buckhalt, et. al. (1990). Alabama. (ERIC Document Reproduction Service No. ED329406*.)

Ecology of alcohol and other drug use: Helping black high-risk youth. Proceedings of the Howard University School of Human Ecology Forum (Washington, D.C., October 26-27, 1987). OSAP Prevention Monograph-7. (1990). Rockville, MD: Alcohol, Drug Abuse, and Mental Health Administration (DHHS/PHS). Office for Substance Abuse Prevention. (ERIC Document Reproduction Service No. ED336456*.)

Drug abuse among minority youth: Advances in research and methodology. National Institute on Drug Abuse Research Monograph 130. (1993). Rockville, MD: National Institute on Drug Abuse (DHHS/PHS). (ERIC Document Reproduction Service No. ED368806*.)

Alcohol and other drug use among hispanic youth: CSAP Technical Report No. 4. M. Delgado & S. Rodriguez-Andrew (1990). Rockville, MD: Center for Substance Abuse Prevention (available from the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847-2345, 800-729-6686.)

Breaking new ground for American Indian and Alaska native youth at risk: Program summaries. CSAP Technical Report No. 3. (1990). Rockville, MD: Center for Substance Abuse Prevention (available from the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847-2345, 800-729-6686.)

---

* To get a copy of an ERIC document, please contact ERIC Clearinghouse at 800-LET-ERIC for ordering and price information.

Drug abuse prevention for high-risk African American children and their families: Re view and model program.
V. B. VanHasselt, M. Hersen, J.A. Null, R.T. Ammerman, O.G. Bukstein, J. McGillivray, & A. Hunter (1993). *Addictive Behaviors, 18*(2), 213-234.

Prevention of alcoholism in black youth.
P. Copeland (1992). In: *Adolescent Substance Abuse: Etiology, Treatment, and Prevention.* G.W. Lawson & A.W. Lawson (Eds.). Gaithersburg, MD: Aspen Publishers.

Patterns of alcohol consumption among suburban adolescent black high school students.
K.H. Beck & M. Zannis (1992). *Journal of Alcohol and Drug Education, 37*(2), 1-13.

Drug use among Black, White, Hispanic, Native American, and Asian American high school seniors (1976-1989): Prevalence, trends, and correlates.
J.G. Bachman, J.M. Wallace, C.L. Kurth, L.D. Johnston, & P.O. O'Malley (1990). *Monitoring the Future.* Ann Arbor, MI: Institute for Social Research (available from Institute for Social Research, The University of Michigan, P.O. Box 1248, Ann Arbor, MI 48106.)

V. Assessment and Treatment

Interviewing guidelines for the clinical evaluation of adolescent substance abuse.
T. M. Anglin (1987). *Pediatric Clinics of North America, 34*(2), 381-398.

Assessment of alcohol and other drug abuse with referred adolescents.
G. L. Fisher & T. C. Harrison (1992). *Psychology in the Schools, 29,* 172-178.

Alcohol and drug problems: A practical guide for counsellors.
B.M. Howard, S. Harrison, V. Carter, & L. Lightfoot (1996). Toronto, Canada: Addiction Research Foundation (available from Addiction Research Foundation, Marketing Dept., 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1; 800-661-1111.)

Adolescent substance abuse treatment: Evolving policy at federal, state, and city levels. Meeting highlights and background briefing report. Report of a family impact seminar (Washington, D.C., November 17, 1989).
(1990). Washington, D. C. : American Association for Marriage and Family Therapy (AAMFT); Research and Education Foundation; Family Impact Seminar (FIS).

---

* To get a copy of an ERIC document, please contact ERIC Clearinghouse at 800-LET-ERIC for ordering and price information.

VI. Evaluation and Financing

Health reform for communities: Financing substance abuse services. Recommendations from Join Together Policy Panel.
(1994). Boston, MA: Join Together. (ERIC Document Reproduction Service No. ED387716*.)

Substance abuse in children and adolescents: Evaluation and intervention.
S. Schinke, G. Botvin, & M. Orlandi (1991). Newbury Park, CA: Sage Publications.

Prevention of drug abuse: Examination of the effectiveness of a program with elementary school children.
P. Church, R. Forehand, C. Brown, & T. Holmed (1990). *Behavior Therapy, 21*(3), 339-347.

Meta-analysis of adolescent smoking prevention programs.
W.H. Bruvold (1993). *American Journal of Public Health, 83*(6), 872-880.

Prevention plus III: Assessing alcohol and other drug prevention programs at the school and community level.
J.A. Linney & A. Wandersman (1991). Rockville, MD: Center for Substance Abuse Prevention (available from the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847-2345, 800-729-6686.)

OSAP Prevention Monograph-1: Stopping alcohol and other drug use before it starts: The future of prevention.
(1989). Rockville, MD: Office of Substance Abuse Prevention (available from the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847-2345, 800-729-6686.)

VII. Curriculum and Program Materials for Practitioners, Teachers, School Counselors, Parents and Community Leaders

Learning to live drug free (1990).

This 40 session curriculum provides a flexible framework for classroom-based prevention efforts for kindergarten through grade 12. It presents the stages of child development as they relate to drug prevention, facts about drugs, suggested lesson plans, tips on working with parents and the community, and a resource section for further information. Teachers can integrate prevention messages into their classroom

---

* To get a copy of an ERIC document, please contact ERIC Clearinghouse at 800-LET-ERIC for ordering and price information.

presentations.
(Available from National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847-2345; 800-729-6686.)

The teenage alcoholic (1991).

This booklet discusses teen alcoholism and looks at why alcohol is the drug of choice for many teenagers. The booklet counters myths about teen alcoholism, addresses alcoholism as a "family problem," and lists signs and symptoms of the disease. Resources for help and information are included.
(Available from Life Skills Education, 314 Washington Street, Northfield, MN 55057-2025; 800-783-6743.)

If you change your mind

This 30-minute video documentary was produced entirely by middle school students for other school children. It presents a child's perspective on drug abuse and its effects. In conjuction with the student magazine and 16-page teacher's guide, this video is a teaching tool to help students learn about the consequences of drug abuse.
(Available from National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847-2345; 800-729-6686.)

Inhalants and their effects

This booklet explains how inhalants affect the brain and other parts of the body. It states that long-term inhalant users are at an increased risk for cancer and that youth are particularly vulnerable to the dangers of inhalants. The booklet looks at reasons why people may being using inhalants and urges teenagers and young adults who are currently using inhalants to seek counseling for help.
(Available from Life Skills Education, 226 Libbey Parkway, Weymouth, MA 02189; 800-783-6743.)

Coping with an alcoholic or drug-abusing parent

This booklet looks at ways in which youth are affected by a substance-abusing parent's behavior. The author points out roles these children may take on and common problems that they may experience. The pamphlet also discusses where families can find help and ways to cope during the recovery process.
(Available from The Bureau for At-Risk Youth, 645 New York Avenue, Huntington, NY 11743; 800-99-YOUTH).

Drugs in the schools: Preventing substance abuse [student text] (1992).

Drugs in the schools is a grade 6-9 program that helps students develop a sense of responsibility for solving substance abuse problems. By developling a plan to confront substance abuse in fictitious Jackson Middle School, students learn to combat or

prevent a possible substance abuse problem in their own school. The curriculum contains seven interactive lesson plans and features cartoon sketches scattered throughout the booklet. A teacher's guide is included.
(Available from Center for Civic Education, 5146 Douglas Fir Road, Calabasas, CA 91302; 818-591-9321.)

"I made it!": Kids who stay in school (1991).

This video, produced by NBC News, interviews students and teachers in a New Jersey high school with a 60 percent senior graduation rate. Dropouts discuss their regrets and jealousies and students boast of their "extra edge" from staying in school through graduation. Scenes of the graduation ceremony, prom, and other high school activities are featured.
(Available from Human Relations Media, 175 Tompkins Avenue, Pleasantville, NY 10570; 800-431-2050.)

Complete student assistance program handbook: Techniques and materials for alcohol/drug prevention and intervention in grades 7-12 (1992).

This handbook provides counselors, administrators, and student assistance personnel with the skills necessary to help pupils suffering with alcohol- and other drug-related problems. The handbook includes a comprehensive guide on how to set up and run a student assistance program, as well as three curricula that contain session-by-session guidelines and ready to use materials.
(Available from The Center for Applied Research in Education, Simon & Schuster, Order
Processing Center, P.O. Box 11071, Des Moines, IA 50336-1071; 800-947-7700.)

Missing persons (The drunk driving holocaust) (1992).

This video unites bereaved parents and friends, permanently disabled victims, and young inmates convicted of vehicular homicide in an attempt to educate students about the direct connection between alcohol, automobile crashes, and death. The video also dispels common myths, provides information on blood alcohol concentration (BAC), and brings the real-life consequences of mixing alcohol with driving into the classroom.
(Available from Cambridge Educational, P.O. Box 2153, Charleston, WV 25328; 800-468-4227.)

For teens only, living with an alcoholic parent (1993).

This pamphlet, specifically designed for teens, answers many questions about alcoholism and living with an alcoholic parent. The pamphlet stresses that children are never responsible for a parent's drinking and that alcoholism is a disease. Resources are also included. (Available from The Bureau for At-Risk Youth, 645 New York Avenue, Huntington, NY 11743; 800-99-YOUTH.)

Right turns only! (1993).

Right turns only! is a television program designed for young students with an accompanying parent's, student's, and teacher's guide. Seven shows focus on the following topics: group belonging and peer pressure, responsibility and identity, goals and the media's mixed message, strength of families and the challenge of alcoholism and other drug abuse, alcohol and other drugs and at-risk behavior concerning AIDS and teenage pregnancy, problem solving and how to deal with hard times, and life can be fun. Students are encouraged to participate in several activities after watching the film, including role-playing, group discussion, identifying related news events in the media, and creating posters.
(Available from Office of Television Resources, Bonnie F. Johns Educational Media Center, Prince Georges' County Public Schools, 8437 Landover Road, Landover, MD 20785; 301-386-1619.)

Mirame: Look at me (1993).

Mirame: Look at me is designed for anyone who leads group activities for Hispanic children ages 9 to 13 years old. The video-based discussion guide has 18 sessions; each session includes topics; specific questions on program themes and activities; exercises that link the program's concepts to action; and in some cases, take home exercises. Four of the 18 sessions show ordinary adolescents successfully engaged in healthy behaviors; 3 sessions show skills to resist social pressure to use alcohol, tobacco, and other drugs; 6 sessions provide role models who demonstrate interpersonal skills for managing family, school, and social life; and 5 sessions focus on creating a positive social support network.
(Available from South Texas Health Research Center, The University of Texas, Health Science Center at San Antonio, 7703 Floyd Curl Drive, San Antonio, TX 78284-7791; 210-614-4496.)

Choosing intervention strategies (1991).

This curriculum is designed to address several facets of intervention with children of alcoholics and other students at high-risk. While it was intended to be used in rural school districts, the basic information may be helpful for all communities. The curriculum includes eight sessions devised to identify, teach, and intervenen with youngsters at-risk. Sessions contain handouts, overheads, and activities.
(Available from Department of Community Health and Nutrition, University of Northern Colorado, Greeley, CO 80639; 303-351-2755.)

Strengthening families (1991).

Family involvement is crucial for solving adolescent alcohol and other drug problems. This curriculum contains four sessins and is designed to assist communities in understanding the importance of family and developing skills that will strengthen families. A list of references and resources is also included.

(Available from Department of Community Health and Nutrition, University of Northern Colorado, Greeley, CO 80639; 303-351-2755.)

Helping your child say "no" (a parent's guide)/ Ayudando a sus hijos a decirle no (guia para los padres) (1990).

This bilingual booklet gives parents of ages 8-12 practical information about alcohol and other drugs and offers suggestions on how to keep their children drug-free. It explains how alcohol affects the body, how to tell if their child has been drinking, why children start to drink, and how to help children refuse peer pressure. A resource guide is also included.
(Available from National Clearinghouse for Alcohol and Information, P.O. Box 2345, Rockville, MD 20847-2345; 800-729-6686.)

Straight up (1988).

This videotape, targeted towards children in grades four through six, contains six 15-minutes episodes that discuss the risks associated with drugs. Actor Lou Gossett Jr., as Cosmo, takes a boy named Ben on a journey in the fate elevator. Ben's travels teach him valuable lessons about why drugs are harmful and how to refuse them. A guide is also available.
(Available from National Clearinghouse for Alcohol and Information, P.O. Box 2345, Rockville, MD 20847-2345; 800-729-6686.)

Take pride in what's inside with . . . . The Insiders: The tobacco temptation (1991).

In this comic book Alpha the robot teaches kids to "Take pride in what you put inside." He shows kids why smoking cigarettes or using other tobacco products is an unhealthy decision. The influence that parents, advertising, and peers have on kids is discussed, and facts about the physical effects of cigarette smoking are mentioned. This material is designed for first to sixth graders.
(Available from Syndistar, Inc., 125 Mallard Street, St. Rose, LA 70087-9471; 800-841-9532.)

Safe spaces: Drug and alcohol prevention education for special needs and drug exposed K-2 children (1992).

Created by Project Healthy Choices, Bank Street College of Education, this training video provides information for educators, parents, and prevention specialists who work with special needs and drug exposed children. The video discusses how these children are at risk for developling an alcohol or other drug problem and how it is necessary to create "safe spaces" for them to grow. Part one of the video addresses awareness, skills, and practice; part two discusses early intervention and family collaboration.
(To get a copy of this video, call National Clearinghouse for Alcohol and Drug Information at 800-729-6686 for the Center nearest you.)

Getting it together: Promoting drug-free communities (1991).

This book provides recommendations and step-by-step directions on how to "get it together" and create drug-free communities. It includes ideas on how to work effectively with youth and suggests how to involve other members of the community. Resources also are listed for further information.
(Available from National Clearinghouse for Alcohol and Information, P.O. Box 2345, Rockville, MD 20847-2345; 800-729-6686.)

You and me tobacco free, children's activities in tobacco awareness (1990).

This book is designed for use with elementary school students and provides extensive information and prevention activities concerning the use of tobacco. The book teaches about the risks of tobacco use and includes chapters such as "Our Bodies and Our Breathing," "Tobacco: No Type is Safe," and "Using Tobacco Makes Our Hearts Unhappy." Lessons are conveyed in a fun and informative manner, and each plan contains suggestions and more ideas for teachers.
(Available from ETR Associates, P.O. Box 1830, Santa Cruz, CA 95061-1830; 800-321-4407.)

The discovery kit: Positive connections for kids.

The discovery kit is a cross-cultural program designed for communities to build resiliency in 10 to 15 year-old children by helping them connect to positive influences in their lives. The messages and materials are designed to help all children but especially children of alcoholics and other children who are at higher risk for developing alcoholism or other drug problems. The kit includes two videos, activity sheets, posters, booklets, and a program guide.
(Available from National Clearinghouse for Alcohol and Information, P.O. Box 2345, Rockville, MD 20847-2345; 800-729-6686.)

Preparing for the drug-free years (1993).

Preparing for the drug-free years (PDFY) is a dynamic educational tool for parents of children about to enter their teens. It is designed to help parents realize the widespread dangers of teen drug use and empower them to develop an action plan to keep drugs out of the family. The curriculum kit includes the following: 35 PDFY Family Activity Books; 1 PDFY Workshop Leaders Guide; 1 set of five PDFY Video Training Tapes; 1 set of A Guide to Adapting PDFY for Diverse Communities; 1 set of PDFY Workshop Transparencies; and one audiocassette: How the Experts Answer the 20 Most Asked Questions About Risks for Drug Abuse.
(Available from Developmental Research & Programs, 130 Nickerson , Suite 107, Seattle, WA 98109; 206-286-1805.)

Parent training is prevention: Preventing alcohol and other drug problems among youth in the family (1991).

This book contains valuable information to help communities identify and carry out programs on effective parenting. It details roles parents play in rearing children who are free of alcohol, tobacco, and other drug problems; highlights ethnic and cultural considerations; and gives characteristics of successful prevention programs.
(Available from National Clearinghouse for Alcohol and Information, P.O. Box 2345, Rockville, MD 20847-2345; 800-729-6686.)

Parental awareness and responsibility (Operation PAR) (1993).

Operation PAR describes the successful operation of a local program in St. Petersburg, Florida, designed to prevent and treat alcohol and other drug problems. It includes an executive summary and lists successes and challenges the program has faced. The book looks at 16 program vignettes and lists several resources for further information.
(Available from National Clearinghouse for Alcohol and Information, P.O. Box 2345, Rockville, MD 20847-2345; 800-729-6686.)

Keeping youth drug-free: A guide for parents, grandparents, elders, mentors, and other caregivers (1996).

This booklet provides the latest information about substance abuse, as well as suggests ways for parents to begin "kitchen table discussions" with youth about marijuana and other drugs. This guide also offers exercises such as ways to establish clear nonuse expectations and to help youth analyze the messages they receive about drugs from the media and peers.
(Available from National Clearinghouse for Alcohol and Information, P.O. Box 2345, Rockville, MD 20847-2345; 800-729-6686.)

Reality check community kit (1996).

A community tool kit intended for helping to prevent or reduce marijuana use. It consists of sample media materials, sample handout materials and camera-ready art, ideas for working with the media, and ideas for conducting a local campaign.
(Available from National Clearinghouse for Alcohol and Information, P.O. Box 2345, Rockville, MD 20847-2345; 800-729-6686.)

We hope you found this to be a useful resource.
There's more where this came from!

This packet has been specially prepared by our Clearinghouse. Other Introductory Packets and materials are available. Resources in the Clearinghouse are organized around the following categories.

CLEARINGHOUSE CATEGORIES

Systemic Concerns

- Policy issues related to mental health in schools
- Mechanisms and procedures for program/service coordination
  - Collaborative Teams
  - School-community service linkages
  - Cross disciplinary training and interprofessional education
- Comprehensive, integrated programmatic approaches (as contrasted with fragmented, categorical, specialist oriented services)
- Issues related to working in rural, urban, and suburban areas
- Restructuring school support service
  - Systemic change strategies
  - Involving stakeholders in decisions
  - Staffing patterns
  - Financing
  - Evaluation, Quality Assurance
  - Legal Issues
- Professional standards
- Other System Topics: ______________________________

Programs and Process Concerns:

- Clustering activities into a cohesive, programmatic approach
  - Support for transitions
  - Mental health education to enhance healthy development & prevent problems
  - Parent/home involvement
  - Enhancing classrooms to reduce referrals (including prereferral interventions)
  - Use of volunteers/trainees
  - Outreach to community
  - Crisis response
  - Crisis and violence prevention (including safe schools)
- Staff capacity building & support
  - Cultural competence
  - Minimizing burnout
- Interventions for student and family assistance
  - Screening/Assessment
  - Enhancing triage & ref. processes
  - Least Intervention Needed
  - Short-term student counseling
  - Family counseling and support
  - Case monitoring/management
  - Confidentiality
  - Record keeping and reporting
  - School-based Clinics
- Other program and process concerns: ______________________________

Psychosocial Problems

- Drug/alcoh. abuse
- Depression/suicide
- Grief
- Dropout prevention
- Learning Problems
- School Adjustment (including newcomer acculturation)
- Pregnancy prevention/support
- Eating problems (anorexia, bulim.)
- Physical/Sexual Abuse
- Neglect
- Gangs
- Self-esteem
- Relationship problems
- Anxiety
- Disabilities
- Gender and sexuality
- Reactions to chronic illness
- Other Psychosocial problems: ______________________________

BEST COPY AVAILABLE